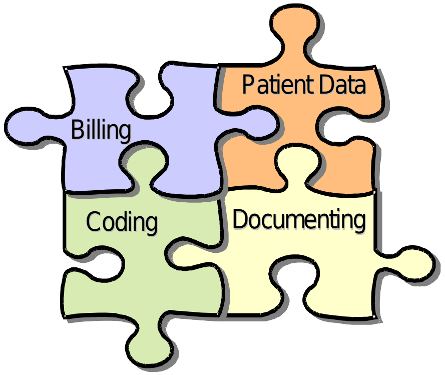
CORE COMPETENCIES

2005 UBU/UBO Conference UBO Advanced (Track 4)

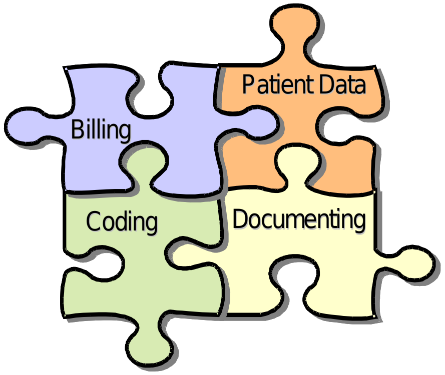
Tuesday - May 17



Contents:

1. Why You Lose Relative Value Units -RVUs (Milster, MSgt JoAnn)
2. HIPAA and the UBO (Sadauskas, Tom)
3. Ambulatory Procedure Visit (APV) Billing for the MHS in 2005 (Yoder, Lt Col Jeanne)
4. Denials 1- Preventing Denials, Clean Claims (Seversen, Bonnie)
5. Denials Management 2 - ‘Don’t Be Puzzled By The Rule’ (Tahban, Bernadette)
6. Patient Category Codes (PATCATs) – What You Don’t Know Can Hurt You! (Coleman, Russ)

CORE COMPETENCIES

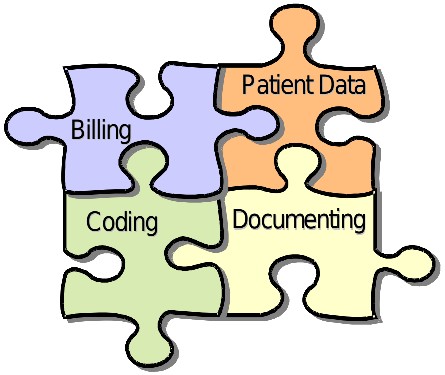

Patient Data
Billing
Coding
Documenting

Why You Lose Relative Value Units (RVUs)

MSgt JoAnn Milster
Air Force Data Quality Manager
aka Green Eyeshade Monster

17 May 2005
Track 4

CORE COMPETENCIES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What is Data Quality?

- Is the accurate reflection of the work performed in the MTF that can be used to make informed leadership/management decisions at all levels of command.

It is the view of your MTF from the “Ivory tower”

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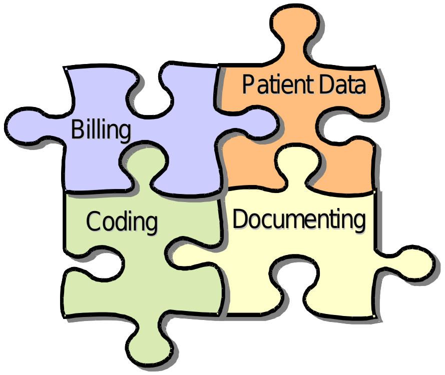
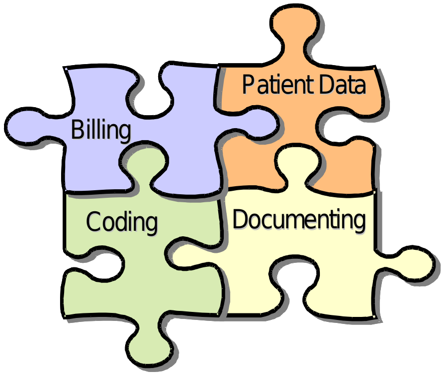

Billing
Patient Data
Coding
Documenting

Overview

- Relative Value Units (RVUs)
- Relative Weighted Product (RWPs)
- Biz Plan Implications



RVU History

- Mandated by Social Security Act, as amended
- Required Medicare Fee Schedule to be based on national uniform Relative Value Units (RVUs)
  - RVUs to be based on the resources used in furnishing a service
- Developed by a research team at the Harvard School of Public Health
  - Input from expert physician panels and physicians from numerous specialties
- Approximately 7,500 codes represent services included in the physician fee schedule in use by Centers for Medicare and Medicaid Services since 1999

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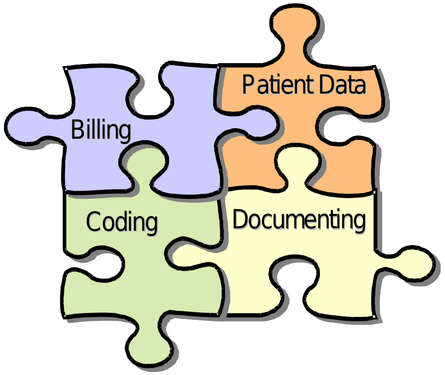
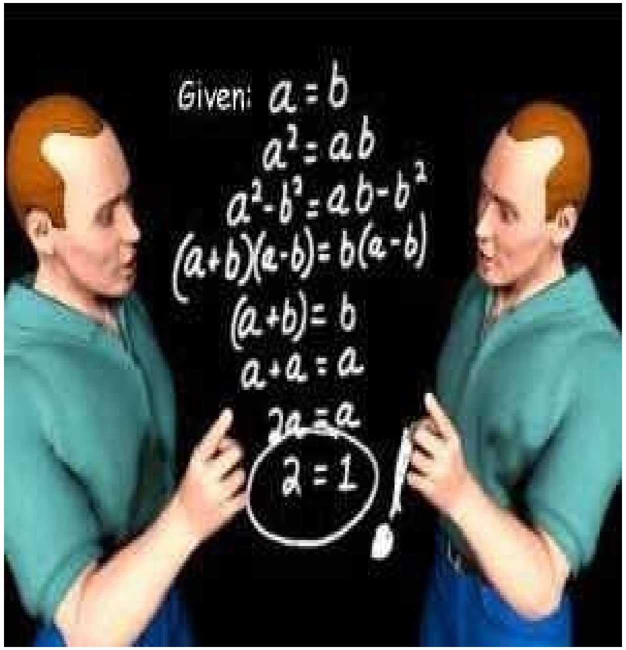


Patient Data
Billing
Coding
Documenting

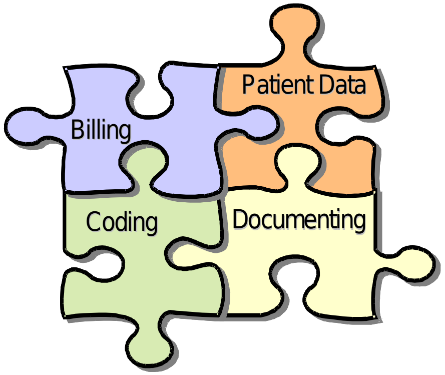
RVUs Defined

- A visit is no longer 1
- “Adjusted” Visit <=> 1.0
  - Based on resource consumption
- Adjustment factor is the **Relative Value Unit** as applied to the “coded” visit (Current Procedural Terminology-CPT)



Given: a=b
a²=ab
a²-b²=ab-b²
(a+b)(a-b)=b(a-b)
(a+b)=b
a+a=a
2a=a
2=1

Types of RVUs



- There are three components of an RVU
  - Physician Work RVU
  - Practice (Facility/Non-Facility) RVU
  - Malpractice RVU
- For direct care outpatient services, HA/TMA use Physician Work RVUs for outpatient productivity, revenue, and cost-related calculations
  - Currently, the only RVUs applied to CPT codes at the MHS Data Repository

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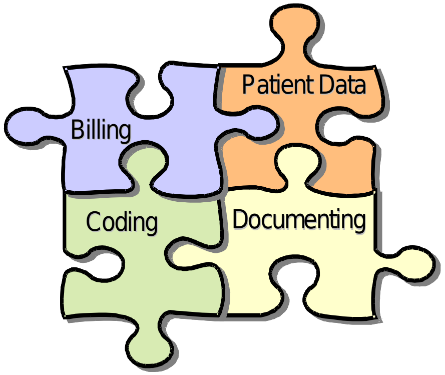
Calculating RVUs


Patient Data
Billing
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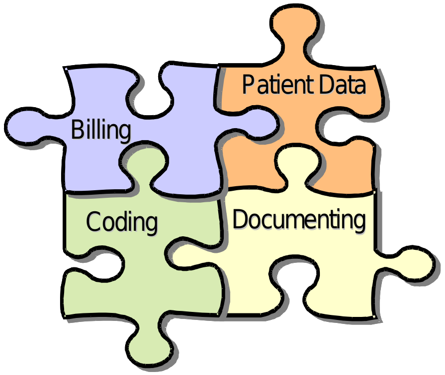
- “Simple” RVUs: Each encounter record can contain up to 5 CPT codes
  - E&M Procedure RVU
  - Procedure 1 RVU through Procedure 4 RVU
  - RVUs for multiple CPTs in a record are accumulated
  - Sum of ***all*** RVUs = **Simple RVUs**

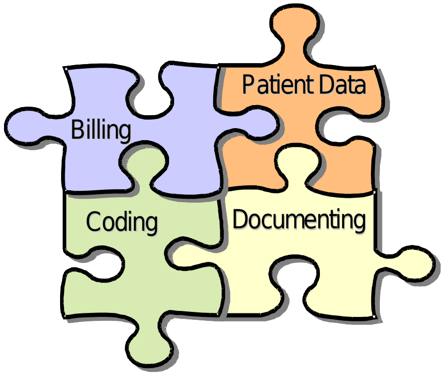
CORE COMPETENCIES

Weights of Common E&M Codes


Patient Data
Billing
Coding
Documenting

CPT	Description	RVU Value
99285	Emergency dept visit	4
99354	Prolonged service, office	2.49
99385	Prev visit, new, age 18-39	2.19
99382	Prev visit, new, age 1-4	1.94
99213	Office/outpatient visit, est	0.94
99205	Office/outpatient visit, new	3.77

Weights of Common Procedures


Billing
Patient Data
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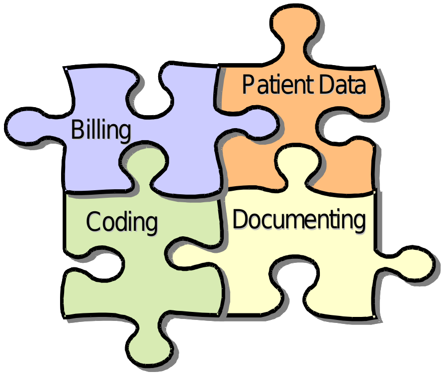
CPT	Description	RVU Value
29835	Elbow arthroscopy/surgery	14.31
73718	Mri lower extremity w/o dye	12.82
24600	Treat elbow dislocation	9.84
45355	Surgical colonoscopy	5.06
76091	Mammogram, both breasts	2.56
11201	Remove skin tags add-on	0.43

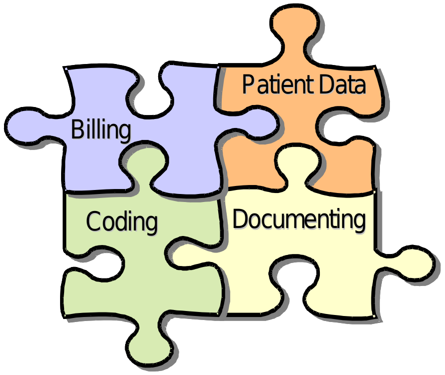
CORE COMPETENCIES



RWPs Defined

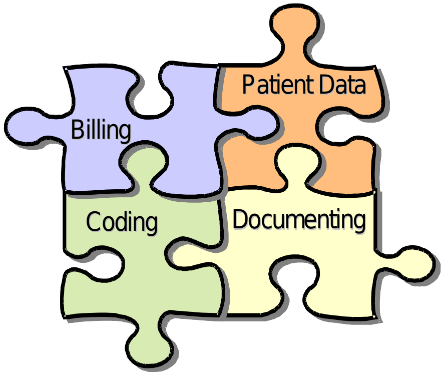
- Like visits, a disposition is no longer just a disposition
- Disposition = 1.0
  - Regardless of resource consumption
- Adjusted disposition <=> 1.0
  - Based on resource consumption
- Adjustment factor is the **Relative Weighted Product** as applied to the “coded” disposition (Diagnosis Related Group - DRG)

“Adjusted” Disposition



- Total Relative Weighted Product for a given disposition is based on:
  - Base RWP = DRG Weight
  - Outlier RWP is +/- the base RWP if the encounter was flagged with a short- or long-stay stay outlier
- Weighting based on DRG length of stay and DRG thresholds for short and long stays
- Applies to “Institutional” workload only; “Professional” workload is billed separately – when we go to Itemized Inpatient Billing
  - MTFs do *currently* capture inpatient “professional” workload in house – IBWA Phase II downtown care -- Jan 06

C O R E C O M P E T E N C I E S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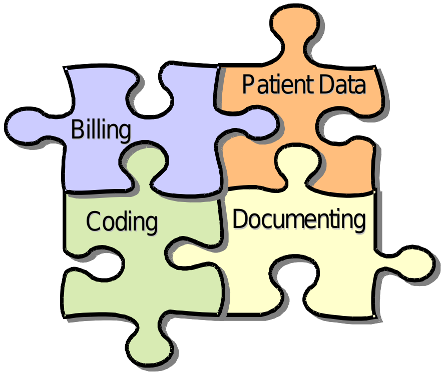
Completeness and accuracy of coding becomes paramount

Bad Code = Poor Payment

No Code = No Payment

Biz Plan Calculations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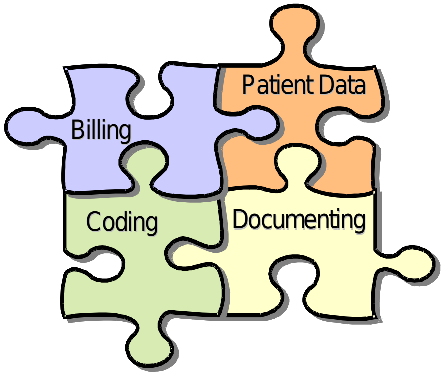
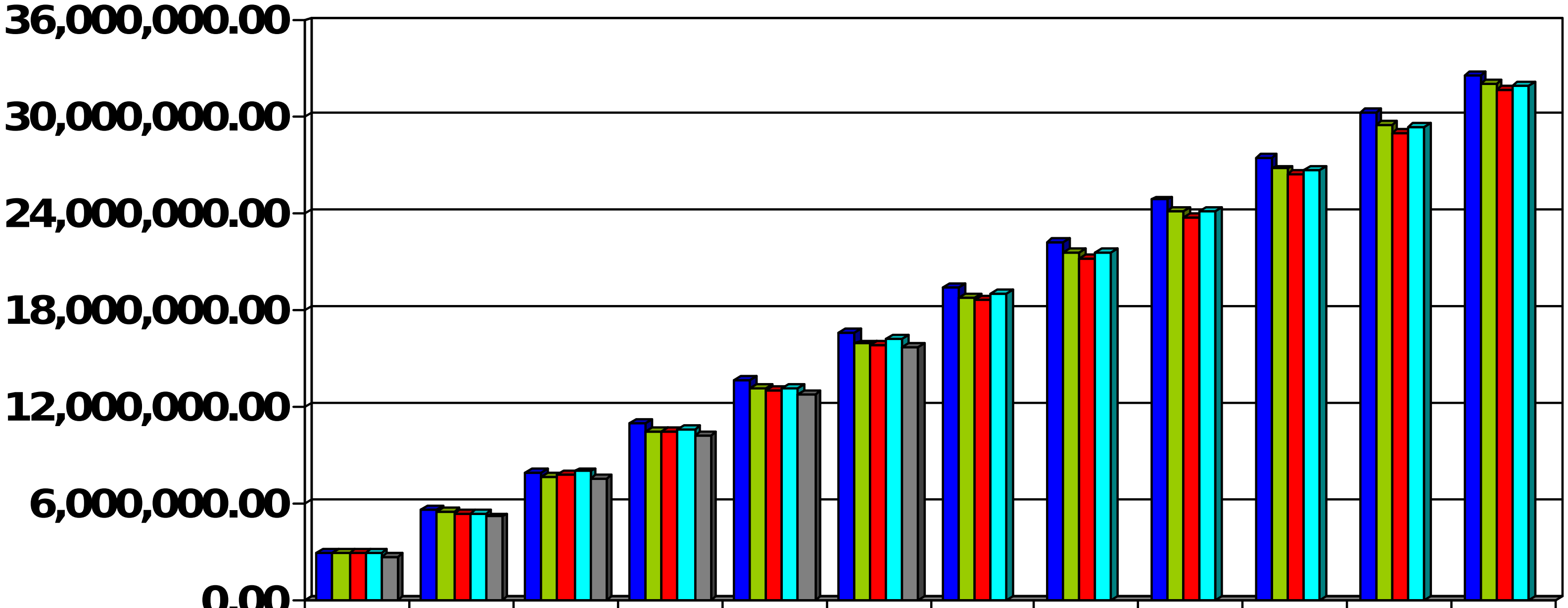
- Total Simple RVUs for all A*** and B***
- Total RWPs for all DRGs
- Ancillary Services
- FTEs per MEPRS time reporting

CORE COMPETENCIES

Worldwide Workload Report MHS





	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
🟦 FY 01 (Cum)	2,873,55	5,564,14	7,929,90	10,907,3	13,615,9	16,615,6	19,394,1	22,241,6	24,855,5	27,441,1	30,255,9	32,547,6
🟩 FY02 (Cum)	2,867,22	5,435,25	7,664,68	10,470,1	13,095,6	15,893,8	18,780,9	21,582,7	24,101,3	26,779,3	29,486,6	32,110,5
🟥 FY03 (Cum)	2,846,96	5,322,99	7,708,06	10,479,3	13,051,1	15,840,1	18,591,1	21,205,6	23,789,8	26,432,9	29,033,0	31,746,6
🟦 FY04 (Cum)	2,870,06	5,283,00	7,949,32	10,539,0	13,146,9	16,193,2	18,996,4	21,549,0	24,190,3	26,684,8	29,396,3	31,975,3
⬜ FY05 (cum)	2,585,49	5,135,63	7,536,32	10,184,5	12,753,8	15,723,6						

Source: M2/WWR (Apr 19, 2005)

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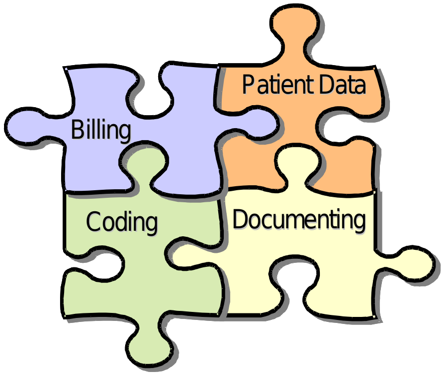
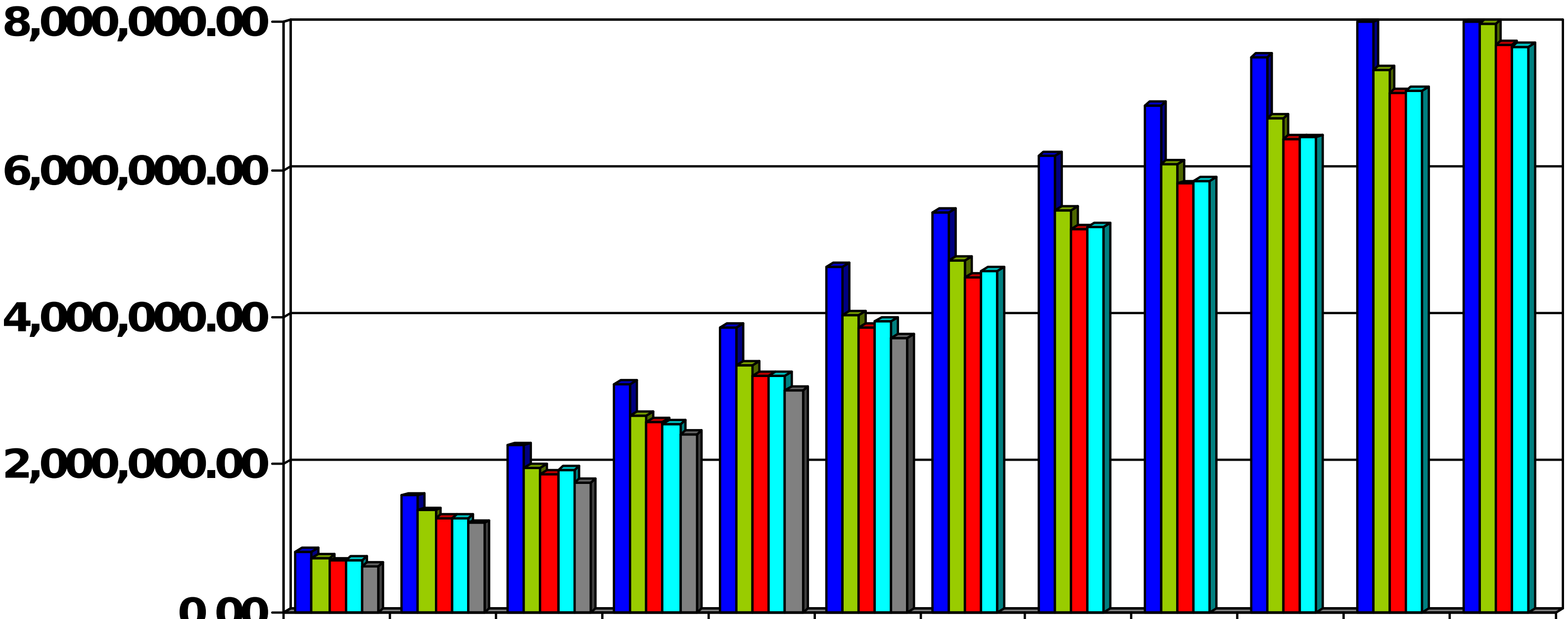
Worldwide Workload Report AFMS



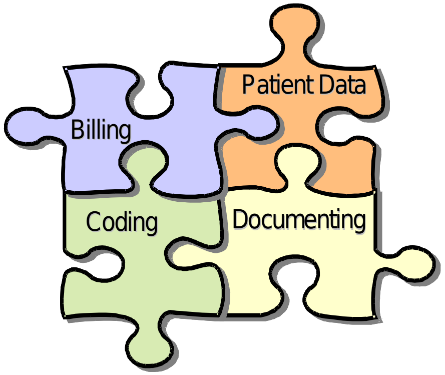


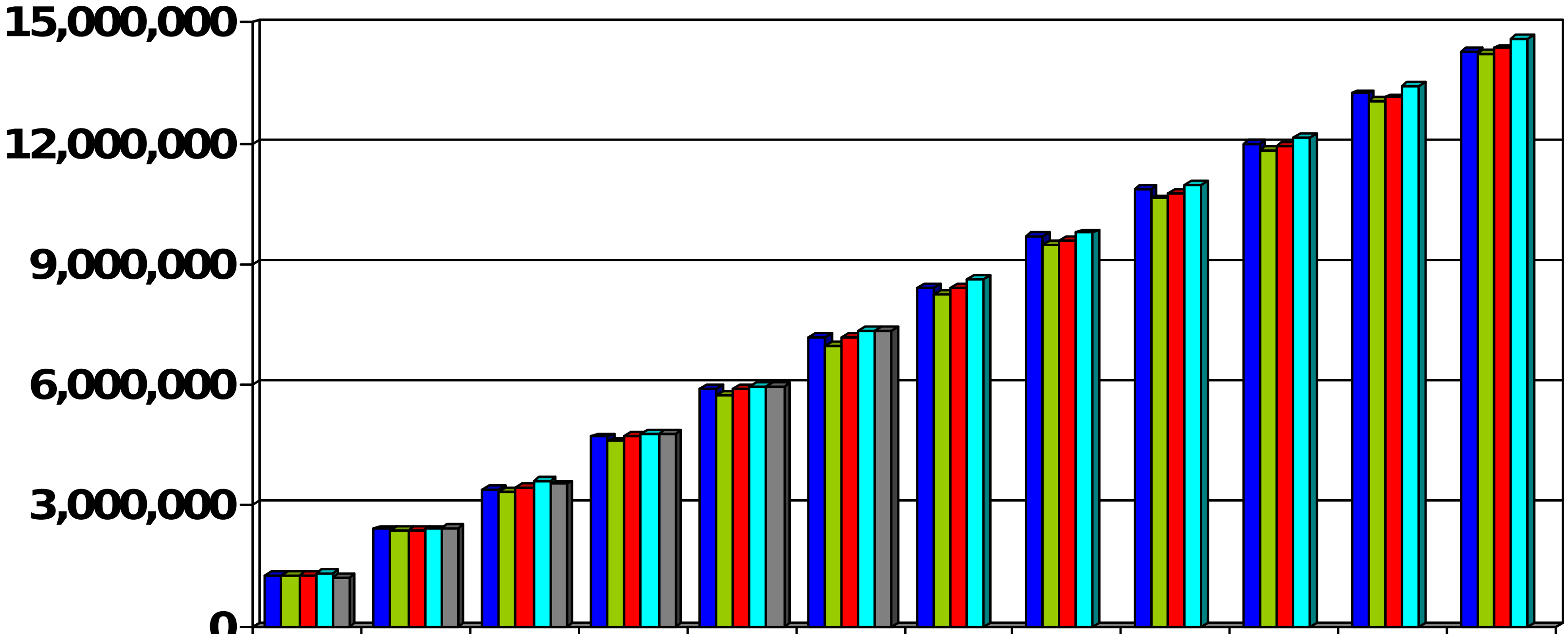
	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
🟦 FY 01 (Cum)	811,138.	1,568,10	2,249,16	3,094,50	3,854,34	4,681,66	5,433,66	6,196,12	6,874,38	7,535,53	8,262,50	8,824,11
🟩 FY02 (Cum)	721,314.	1,368,21	1,950,57	2,672,92	3,335,82	4,030,74	4,758,14	5,459,78	6,067,94	6,704,42	7,355,45	7,981,78
🟥 FY03 (Cum)	685,656.	1,279,77	1,877,76	2,567,67	3,192,76	3,867,82	4,548,81	5,185,02	5,805,37	6,426,67	7,042,85	7,702,54
🟦 FY04 (Cum)	698,266.	1,266,65	1,918,61	2,557,08	3,198,10	3,939,14	4,618,80	5,230,42	5,859,05	6,431,00	7,071,32	7,669,84
⬜ FY05 (cum)	609,164.	1,195,37	1,762,49	2,396,20	3,013,65	3,713,72						

Source: M2/WWR (Apr. 19, 2005)

CORE COMPETENCIES

Worldwide Workload Report Army



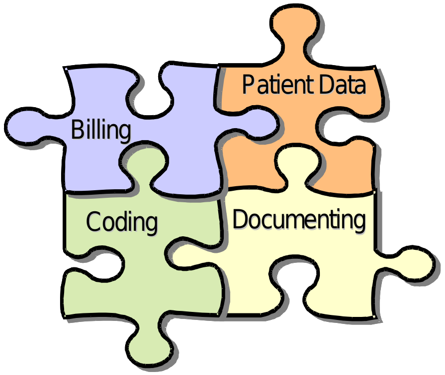


	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
🟦 FY 01 (Cum)	1,239,14	2,406,71	3,409,07	4,703,73	5,882,24	7,197,05	8,423,35	9,683,00	10,844,4	11,999,5	13,233,4	14,265,1
🟩 FY02 (Cum)	1,265,25	2,399,29	3,357,25	4,592,14	5,738,16	6,978,51	8,254,64	9,490,45	10,617,2	11,823,5	13,031,3	14,215,5
🟥 FY03 (Cum)	1,277,64	2,400,51	3,452,41	4,713,17	5,884,03	7,159,58	8,405,93	9,585,24	10,755,3	11,949,1	13,126,7	14,360,0
■ FY04 (Cum)	1,297,17	2,400,88	3,605,07	4,769,65	5,948,76	7,327,85	8,607,70	9,765,39	10,978,9	12,140,2	13,401,1	14,608,5
■ FY05 (cum)	1,204,43	2,410,25	3,527,33	4,760,68	5,963,63	7,359,90						

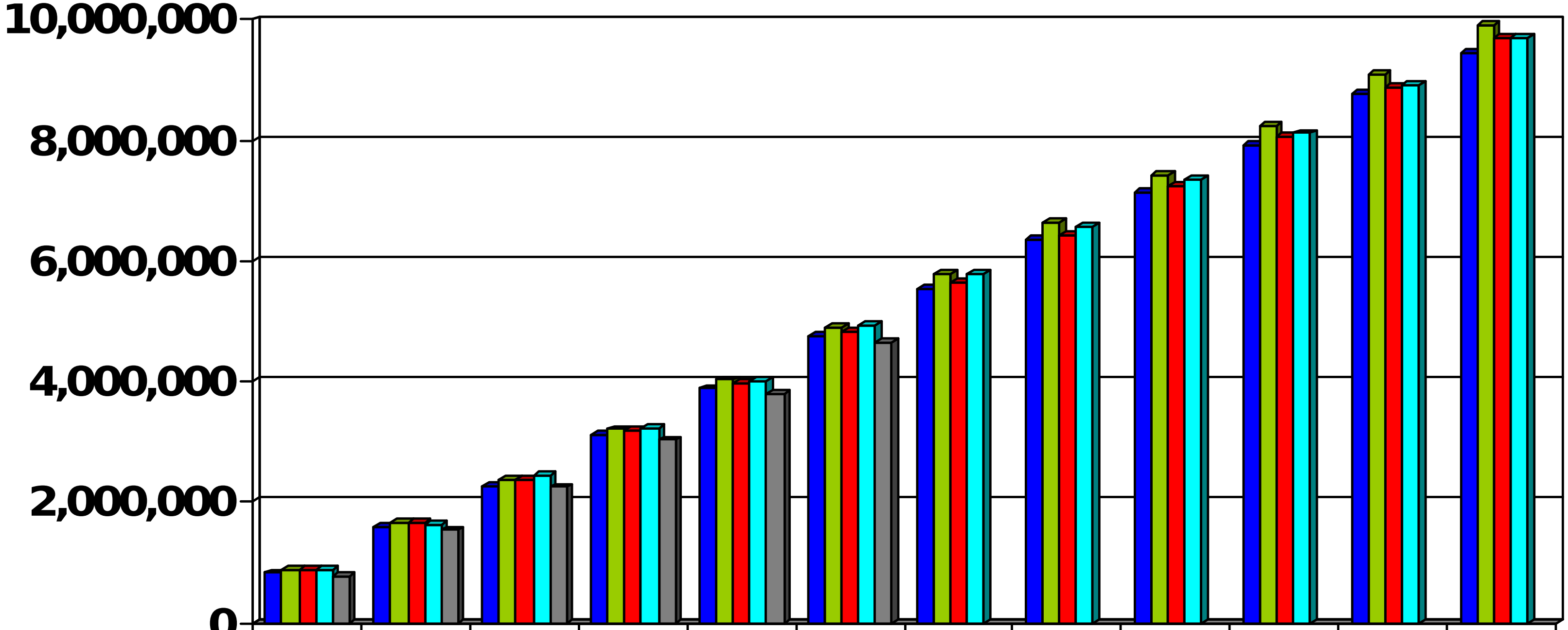
Source: M2/WWR (Apr 19, 2005)

CORE COMPETENCIES

Worldwide Workload Report



Navy

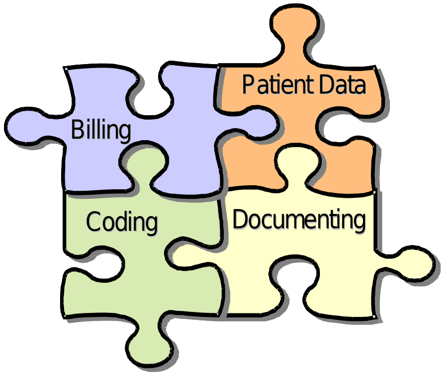


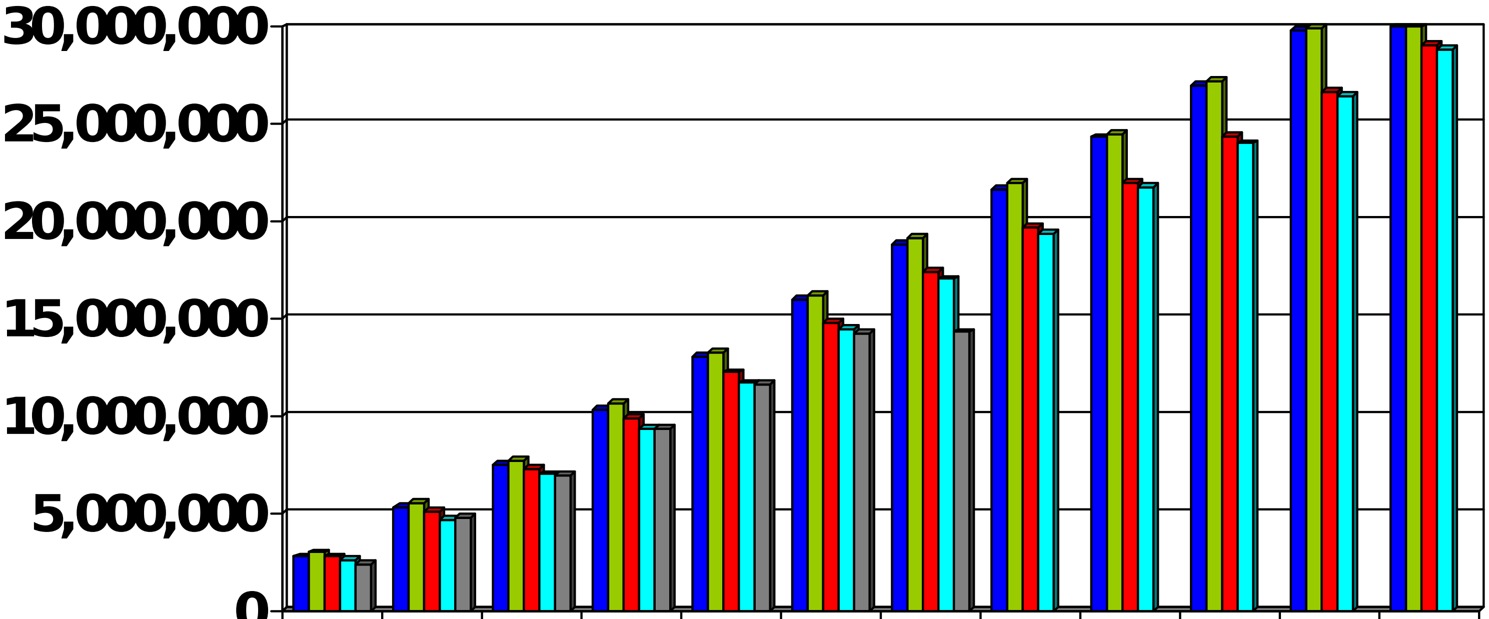
	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
🟦 FY 01 (Cum)	823,277.	1,589,32	2,271,66	3,109,14	3,879,34	4,736,97	5,537,10	6,362,48	7,136,67	7,906,06	8,760,02	9,458,34
🟩 FY02 (Cum)	880,655.	1,667,74	2,356,85	3,205,08	4,021,66	4,884,58	5,768,14	6,632,51	7,416,22	8,251,39	9,099,77	9,913,15
🟥 FY03 (Cum)	883,666.	1,642,70	2,377,88	3,198,49	3,974,38	4,812,69	5,636,42	6,435,35	7,229,08	8,057,11	8,863,49	9,683,99
▢ FY04 (Cum)	874,623.	1,615,46	2,425,63	3,212,30	4,000,12	4,926,26	5,769,92	6,553,24	7,352,35	8,113,58	8,923,82	9,696,94
▨ FY05 (cum)	771,894.	1,530,01	2,246,49	3,027,66	3,776,60	4,650,04						

Source: M2/WWR (Apr. 19, 2005)

CORE COMPETENCIES

Relative Value Unit (RVU) Report MHS





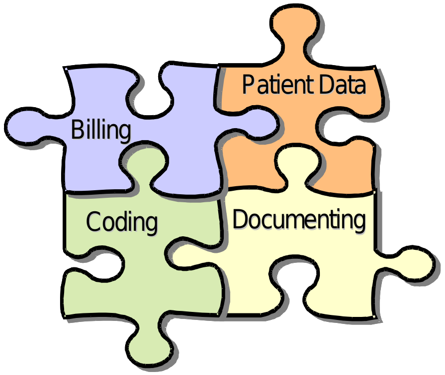
	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
🟦 FY 01	2,728,24	5,297,16	7,472,14	10,337,5	13,006,3	16,002,6	18,779,7	21,656,7	24,316,2	26,949,5	29,831,1	32,129,4
🟩 FY02	2,945,62	5,541,31	7,729,61	10,605,1	13,295,1	16,172,8	19,149,7	22,002,1	24,519,3	27,197,9	29,893,3	32,465,6
🟥 FY03	2,731,68	5,055,37	7,233,96	9,844,16	12,226,5	14,803,3	17,361,1	19,702,8	21,989,6	24,336,4	26,651,9	29,043,9
🟦 FY04	2,552,38	4,680,50	6,978,50	9,313,96	11,678,9	14,475,5	17,015,5	19,324,3	21,729,2	23,999,2	26,423,1	28,803,1
⬜ FY05	2,380,49	4,731,74	6,924,49	9,336,48	11,650,8	14,223,0	14,295,2					

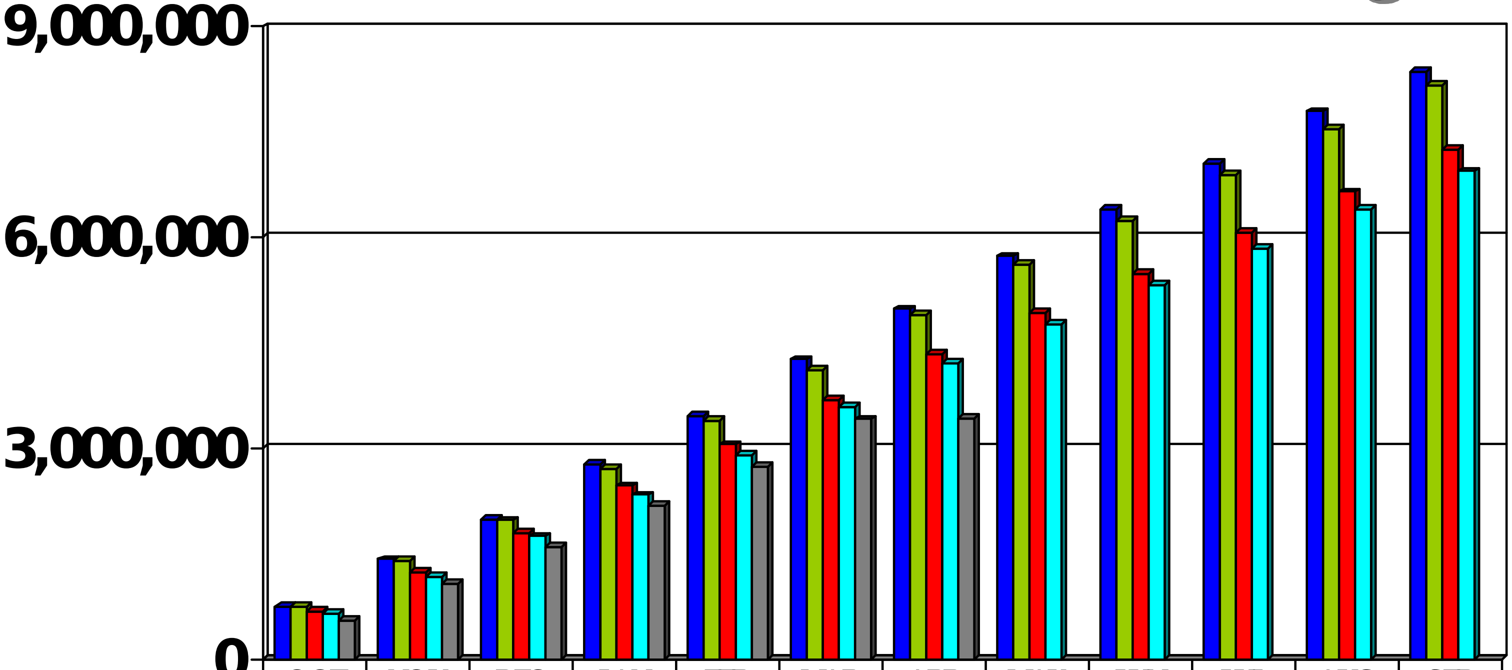
Source: M2 (Apr 29, 2005)

NOTE: All SADR files without filters.

CORE COMPETENCIES

Relative Value Unit (RVU) Report AFMS





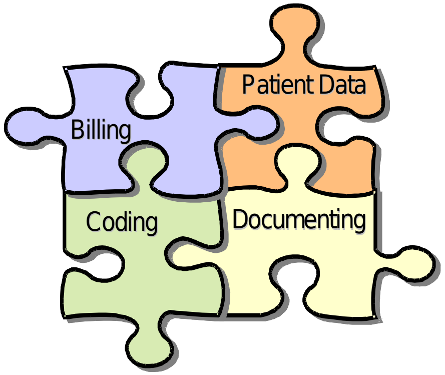
	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
🟦 FY 01	729,482.	1,408,87	1,989,43	2,756,90	3,465,53	4,253,46	4,976,74	5,726,50	6,394,34	7,049,59	7,789,06	8,346,21
🟩 FY02	744,084.	1,397,00	1,967,43	2,711,73	3,398,61	4,119,21	4,880,45	5,606,02	6,221,70	6,874,47	7,542,24	8,171,94
🟥 FY03	672,016.	1,240,29	1,797,03	2,455,50	3,047,94	3,690,45	4,335,11	4,914,79	5,484,04	6,065,13	6,641,81	7,250,90
▢ FY04	643,314.	1,160,97	1,737,94	2,323,17	2,905,65	3,585,84	4,206,16	4,752,23	5,316,04	5,831,28	6,399,34	6,936,60
▨ FY05	546,573.	1,075,87	1,587,76	2,171,31	2,746,21	3,402,13	3,421,62					

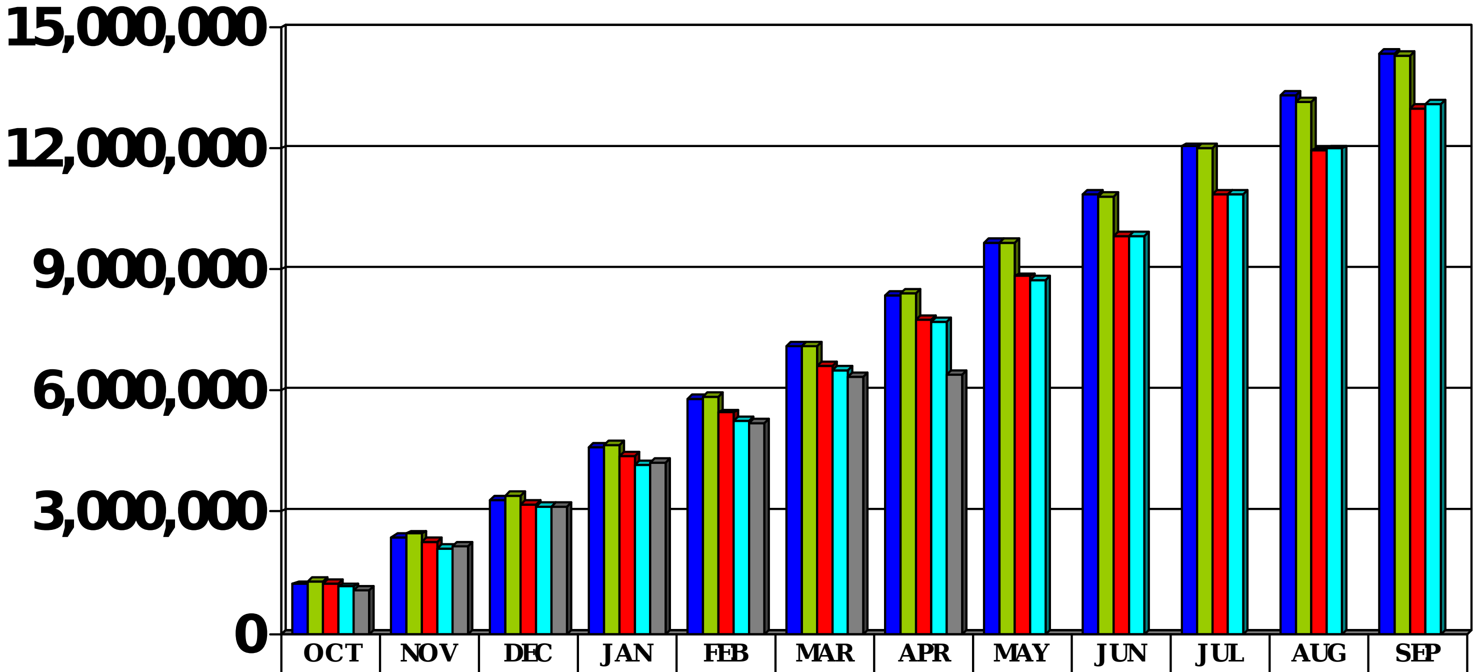
Source: M2 (Apr 29, 2005)

NOTE: All SADR files without filters.

CORE COMPETENCIES

Relative Value Unit (RVU) Report Army





	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
🟦 FY 01	1,206,83	2,357,42	3,318,99	4,601,53	5,797,09	7,139,88	8,390,25	9,679,05	10,871,1	12,047,1	13,319,1	14,364,5
🟩 FY02	1,302,94	2,452,87	3,400,66	4,672,09	5,843,62	7,125,14	8,436,25	9,687,83	10,812,6	12,004,8	13,181,3	14,321,3
🟥 FY03	1,212,67	2,254,33	3,207,44	4,379,42	5,450,99	6,616,43	7,774,29	8,832,80	9,855,34	10,898,7	11,945,8	13,026,3
🟦 FY04	1,145,43	2,110,81	3,138,14	4,185,49	5,258,36	6,529,63	7,700,15	8,747,89	9,849,59	10,893,0	11,999,4	13,095,1
⬛ FY05	1,079,18	2,149,94	3,135,90	4,210,04	5,228,49	6,372,93	6,404,74					

Source: M2 (Apr 29, 2005)

NOTE: All SADR files without filters.

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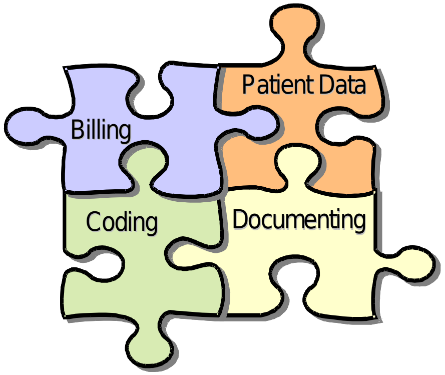
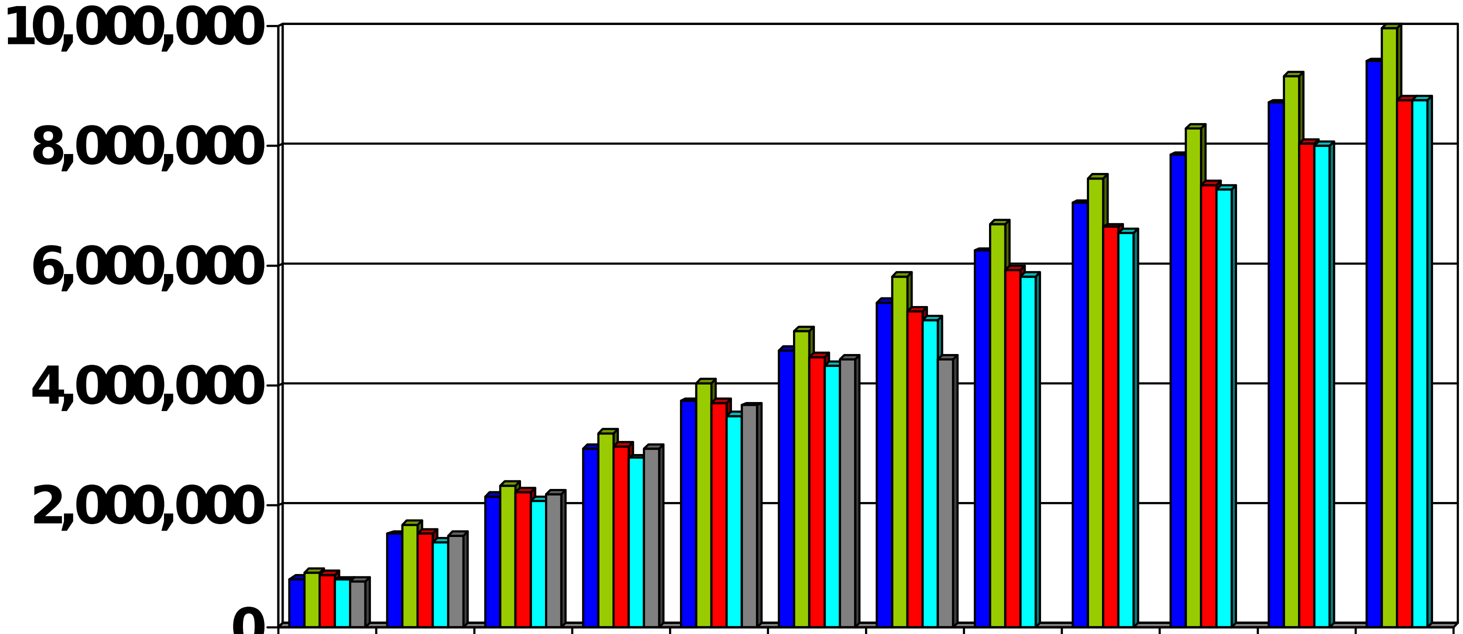
Relative Value Unit (RVU) Report Navy



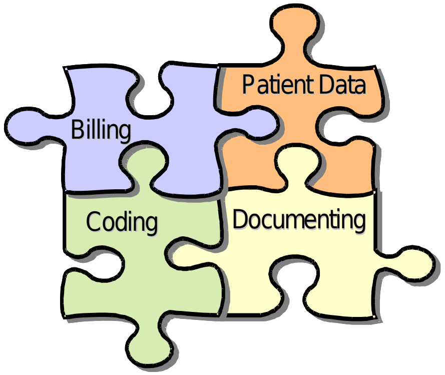


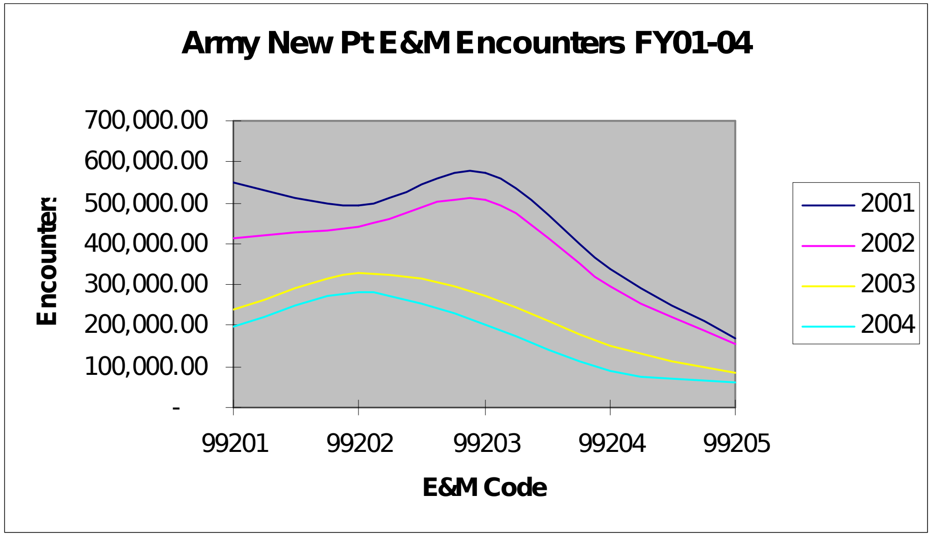
	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
🟦 FY 01	791,920.	1,530,86	2,163,71	2,979,09	3,743,72	4,609,29	5,412,70	6,251,22	7,050,73	7,852,81	8,722,99	9,418,71
🟩 FY02	898,597.	1,691,43	2,361,52	3,221,34	4,052,90	4,928,48	5,833,03	6,708,25	7,485,03	8,318,57	9,169,77	9,972,36
🟥 FY03	846,992.	1,560,74	2,229,48	3,009,23	3,727,62	4,496,47	5,251,69	5,955,22	6,650,22	7,372,49	8,064,24	8,766,67
■ FY04	763,638.	1,408,71	2,102,42	2,805,30	3,514,90	4,360,04	5,109,20	5,824,22	6,563,58	7,274,86	8,024,35	8,771,34
■ FY05	754,740.	1,505,92	2,200,82	2,955,12	3,676,13	4,447,97	4,468,82					

Source: M2 (Apr 29, 2005)

NOTE: All SADR files without filters.

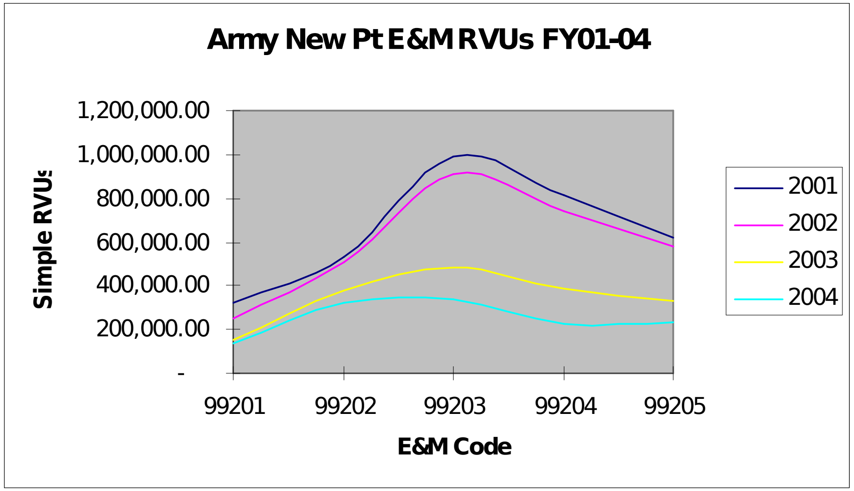
CORE COMPETENCIES


Patient Data
Billing
Coding
Documenting

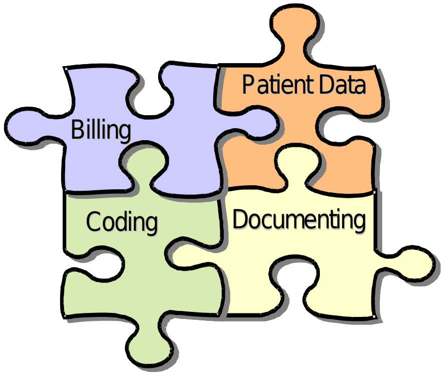


New Pt RVUs/Encounter

2001	**2002**	**2003**	**2004**
1.55	1.65	1.62	1.52



CORE COMPETENCIES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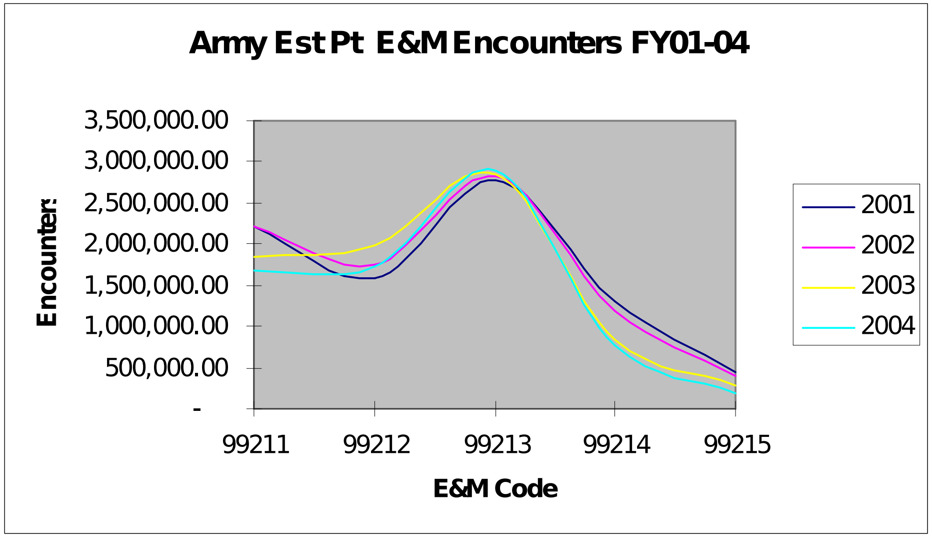
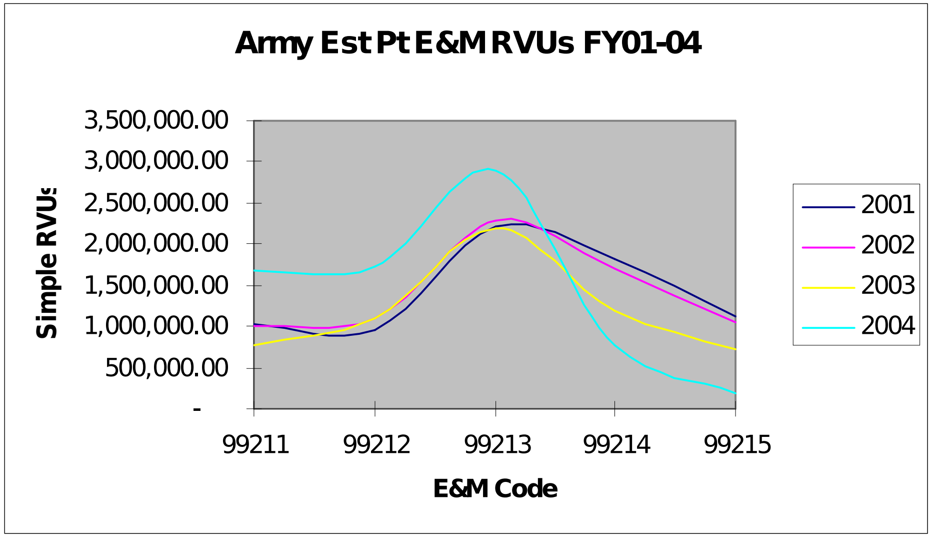
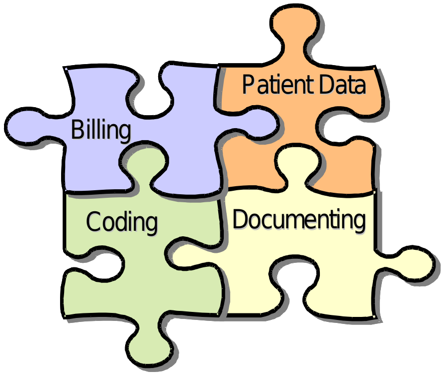


Est Pt RVUs/Encounter

2001	2002	2003	2004
0.86	0.85	0.77	0.74



CORE COMPETENCIES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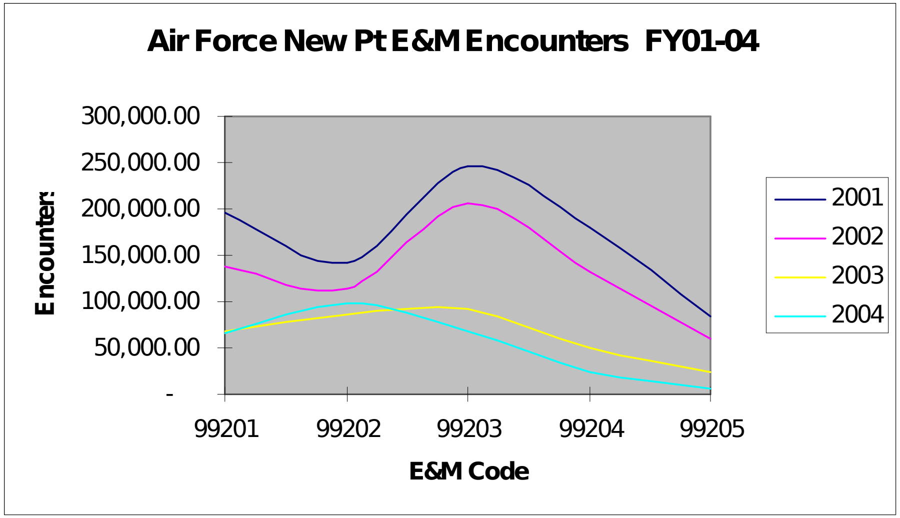
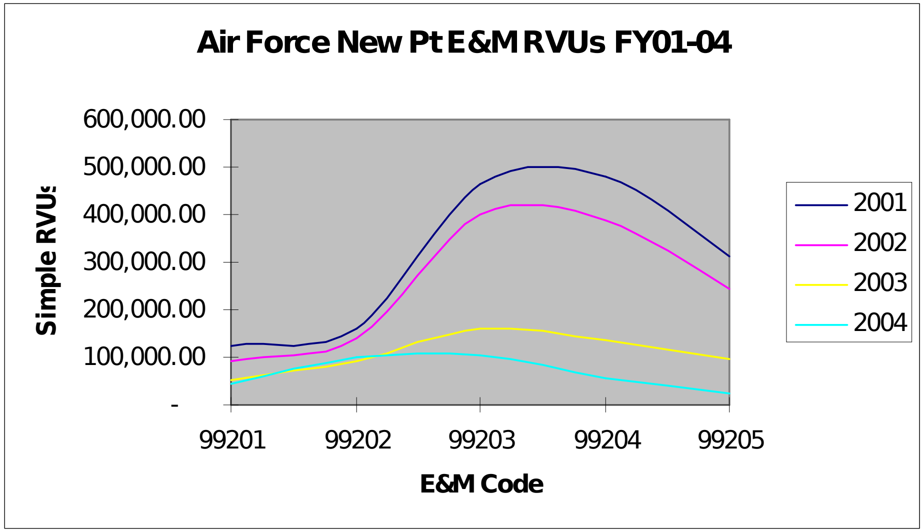
Documenting

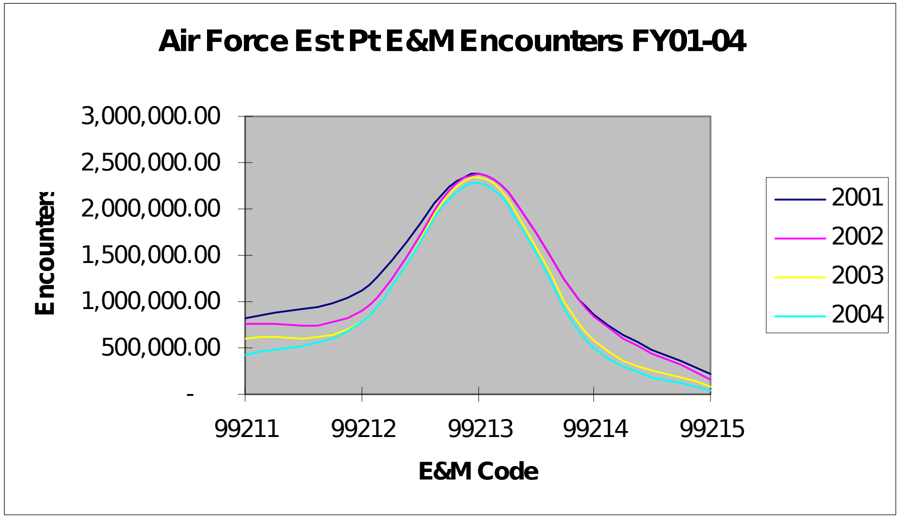


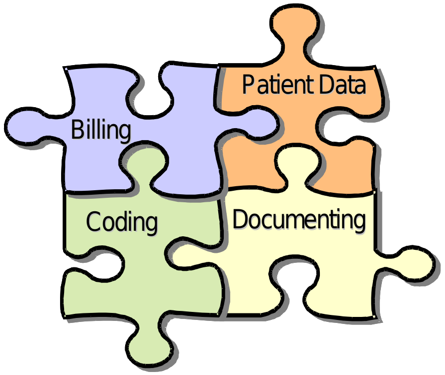


New Pt RVUs/Encounter

2001	**2002**	**2003**	**2004**
1.82	1.94	1.67	1.24

CORE COMPETENCIES




Patient Data
Billing
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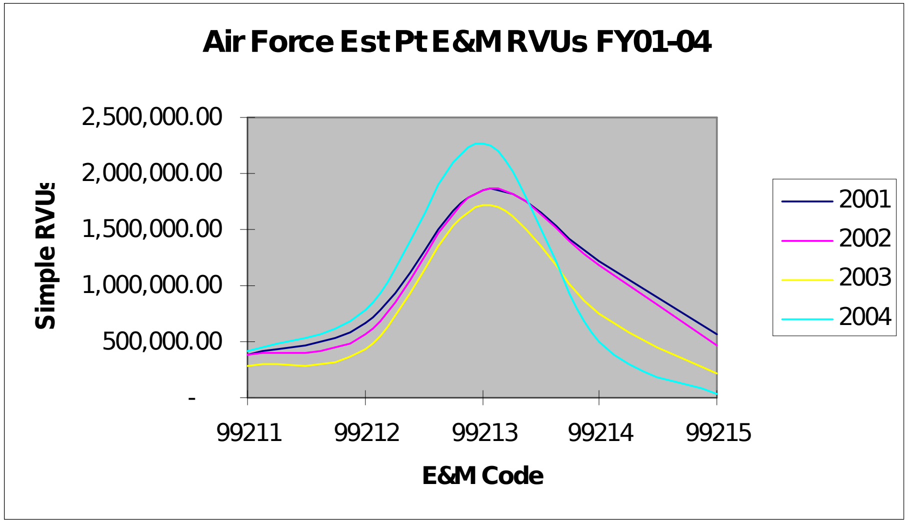
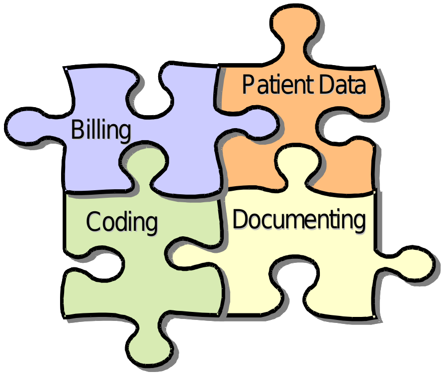
Documenting

Est Pt RVUs/Encounter

2001	2002	2003	2004
0.87	0.88	0.77	0.72



CORE COMPETENCIES


Patient Data
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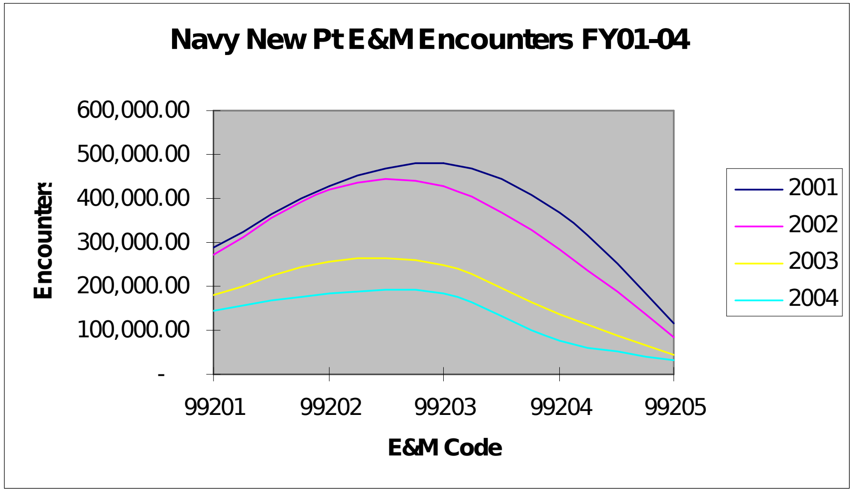
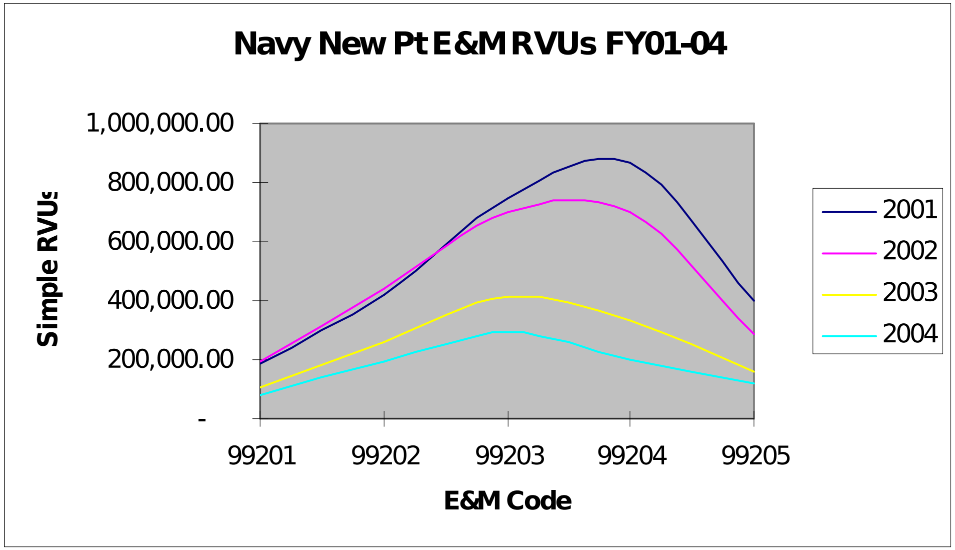
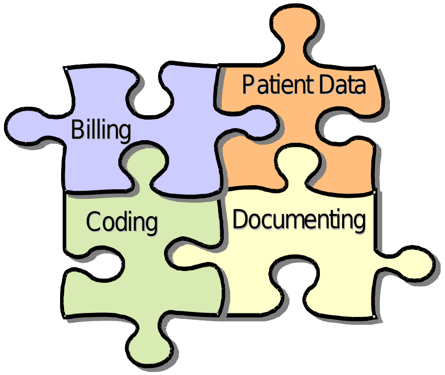


New Pt RVUs/Encounter

2001	2002	2003	2004
1.56	1.56	1.47	1.44



CORE COMPETENCIES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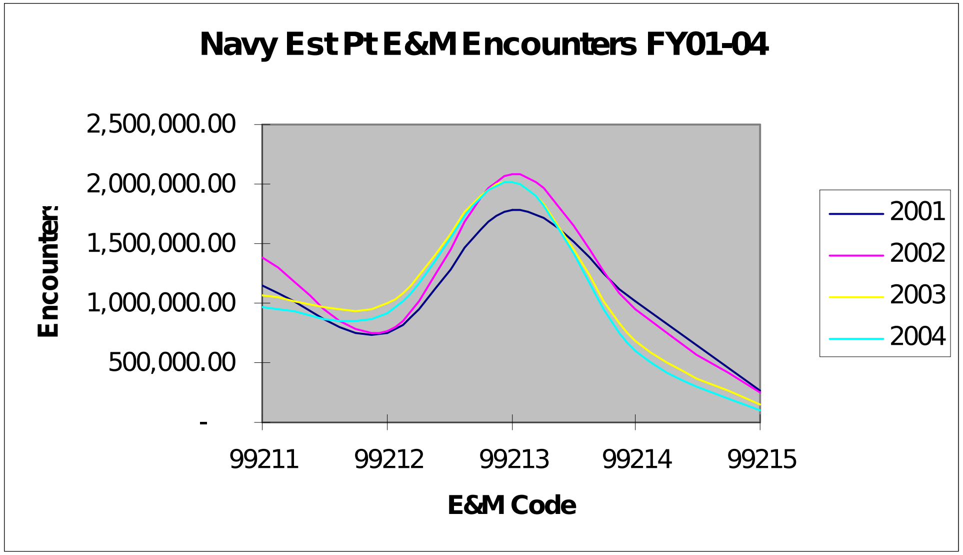
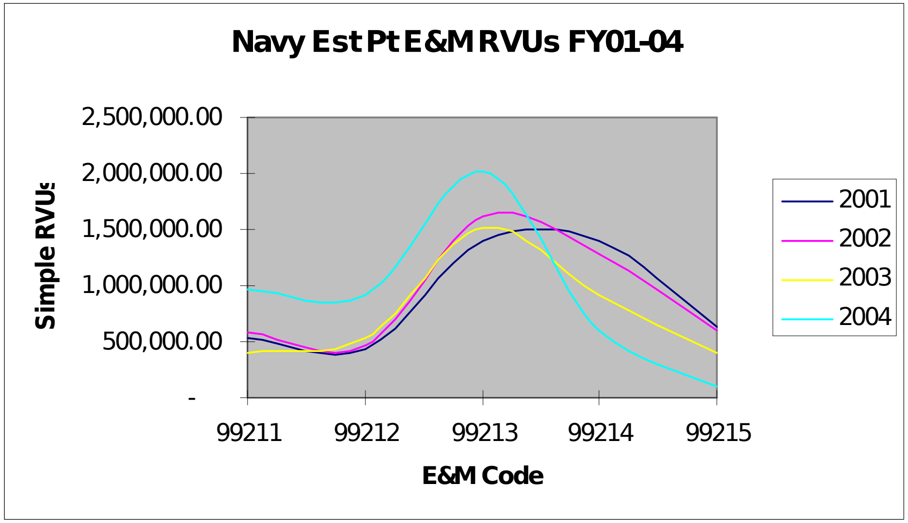
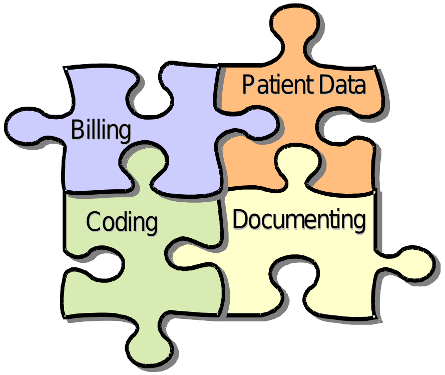


Est Pt RVUs/Encounter

2001	2002	2003	2004
0.89	0.84	0.76	0.74

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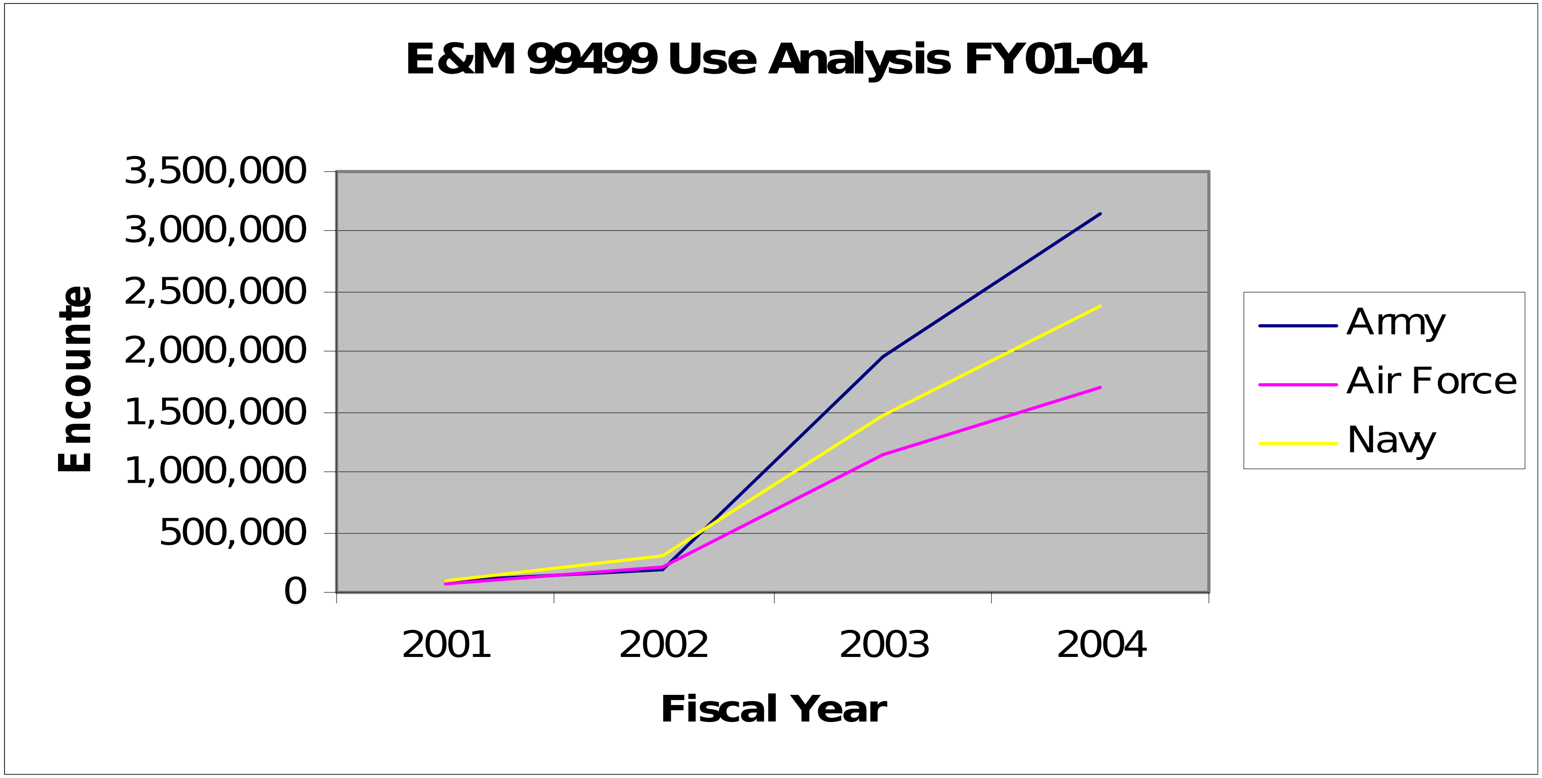
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2004
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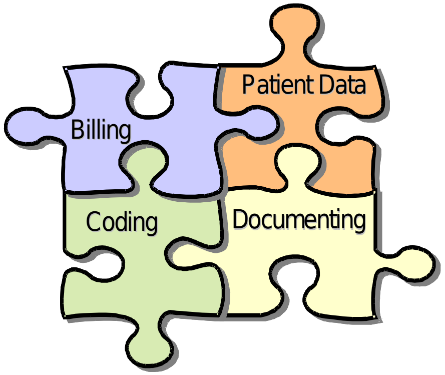
Army
Air Force
Navy

CORE COMPETENCIES

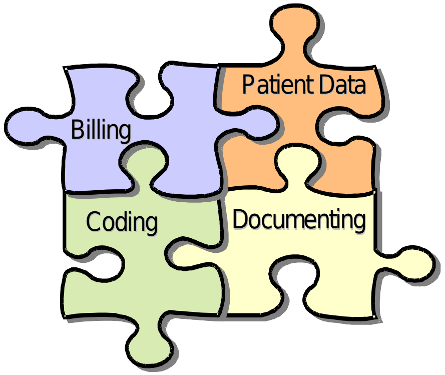

Patient Data
Billing
Coding
Documenting

***Completeness* and *accuracy* of coding becomes paramount**

Bad Code = Poor Payment

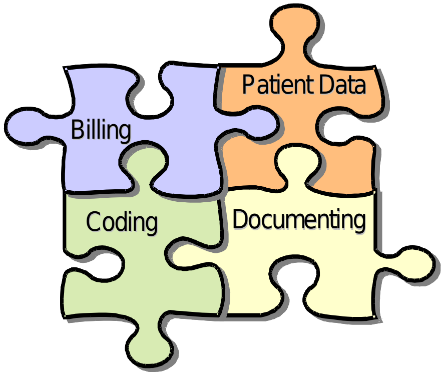
No Code = No Payment

Why is This Happening?


Patient Data
Billing
Coding
Documenting

- Ask a provider and the common answers are:
  - The coder is playing it safe…
  - I didn’t learn coding in medical school…
  - The coding training I received was to general…
  - Where is the incentive for me to code?
  - I don’t have enough manpower in my clinic…

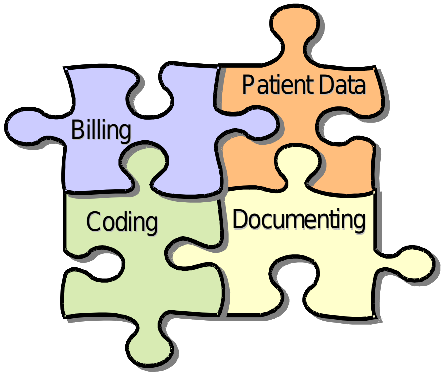
Why is This Happening?


Billing
Patient Data
Coding
Documenting

- Ask a coder and the common answers are:
  - The provider is not documenting…
  - CMS rules are…
  - I don't understand why DoD codes wrong…
  - The provider doesn't listen to me…
  - How can I make the provider…
  - I don't have enough time to do my job

CORE COMPETENCIES

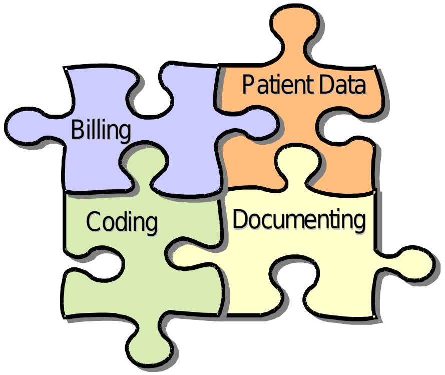
What Does the Data Say?


Patient Data
Billing
Coding
Documenting

- Workload is down across the Military Health Service (MHS)
- Our coding is showing that we are seeing less acute patients

CORE COMPETENCIES

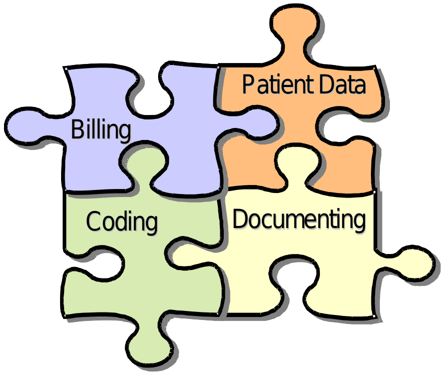
Bridging the Gap



- What is the Truth?
  - Providers need help to document correctly
    - Add to GME Program
    - Training at Provider conferences
    - CHCSII templates will help if set up correctly
  - MTFs need Coders to look for opportunities
    - Providers need positive feedback to improve
    - Provide one-on-one and/or specialty group coding training
    - PRO-Staff meetings
    - Work with GPMs to improve records management
    - Get trained as a CHCSII Super User to help providers, reduce your workload

CORE COMPETENCIES

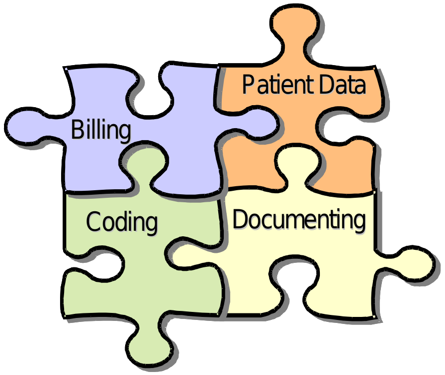
MEPRS link to Coding and Billing



- **MEPRS Code assignment**
  - Recommend MEPRS Program Manager is the only person to assign MEPRS codes
  - Must conform to WAM business rules or workload will not transmit to WWR or EAS IV
- ***Note if you use a MEPRS code that is for Minutes of Service***
  - ***ZERO RVU credit***
  - ***Will not flow to TPOCS – NO BILL PRODUCED***

CORE COMPETENCIES

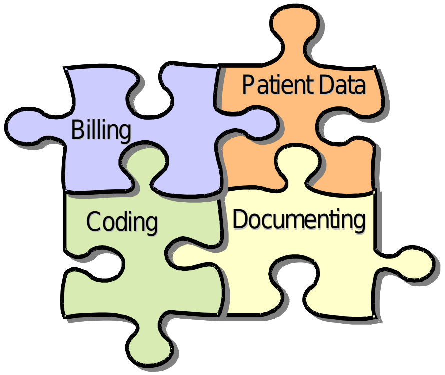
Low Hanging Fruit



- Ensure when coding that you are using the correct MEPRS code
  - DG** is for minutes of service
  - Invalid MEPRS codes, e.g., BZZZ, PMTA
- Ensure your providers have the the correct Provider Specialty Code
  - Under the FY06 PPS methodology
    - AF has lost 44K RVUs
    - Army has lost 392K RVUs
    - Navy has lost 344K RVUs

CORE COMPETENCIES

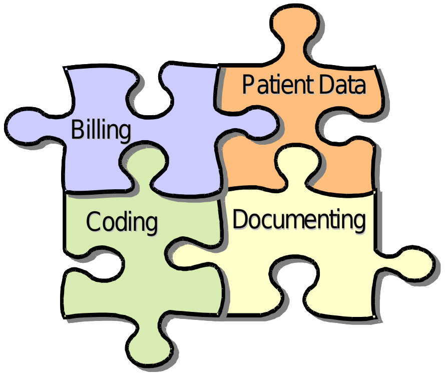
Biz Plan RVU Assignment Basics



- If the CPT/E&M has a CMS weight = CMS rate
- If the CPT/E&M doesn’t have a CMS weight, but does have an Ingenix weight = Ingentix rate
- If the CPT/E&M doesn’t have a weight on either table, a calculation of CPT/E&Ms in the same “family of codes” is done and a quasi RVU is assigned
- OB Global codes are ZERO
- Other CPTs with Global periods are inter-operatory rate with 99024 getting a quasi rate assigned

CORE COMPETENCIES

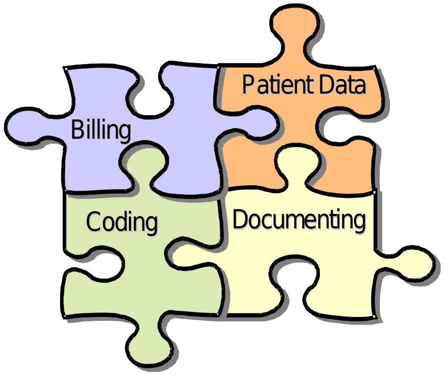
Take Aways


Patient Data
Billing
Coding
Documenting

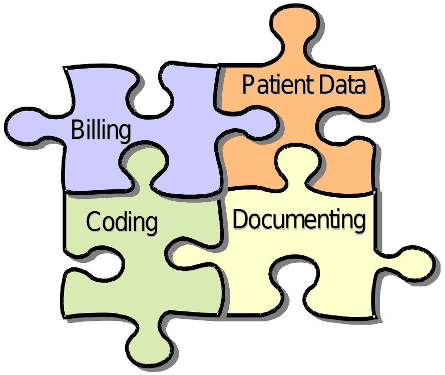
- Understanding of RVU’s and RWPs
  - Data Access (M2, Business Plan Push Reports)
  - http://cms.hhs.gov/ type “RWP” or “RVU” in search engine
- Get to know the Level of Effort historically associated with your market segments
  - Business Plan Reports/Data

C O R E C O M P E T E N C I E S

MEPRS
Part of the Equation



- Equally important is MEPRS reporting
  - Data is used daily by HA/TMA, for and against us
    - MEPRS Data may be used to determine staff productivity
  - Ensure reports are complete and submitted within 45 days
  - Ensure time is captured in appropriate setting (clinical, meetings, readiness, military other, etc.)
  - Use your GPMs to oversee clinical reporting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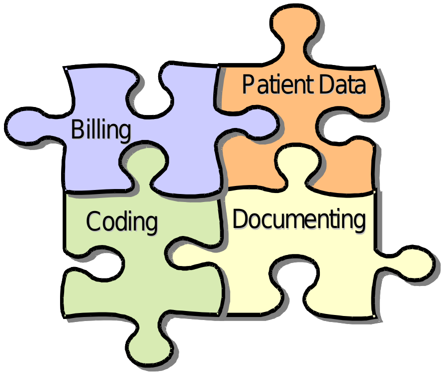
CORE COMPETENCIES

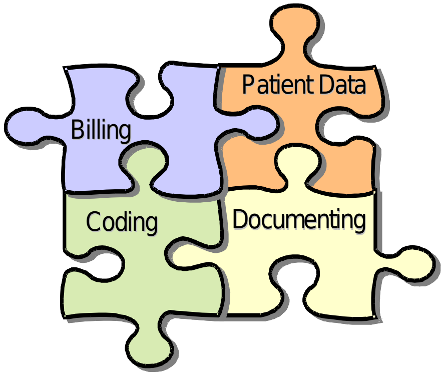

Patient Data
Billing
Coding
Documenting

HIPAA and the UBO

Tom Sadauskas
UBO Deputy Program Manager
Tuesday, 1110-1205, 17 May 2005
Track 4 – Advanced UBO

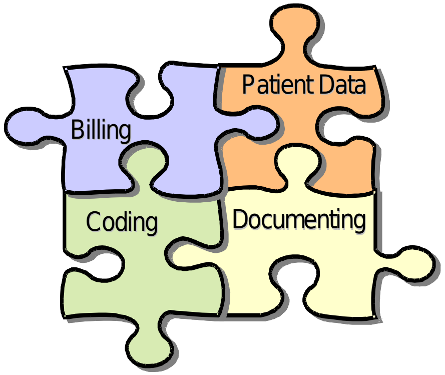
CORE COMPETENCIES

Presentation Overview


Patient Data
Billing
Coding
Documenting

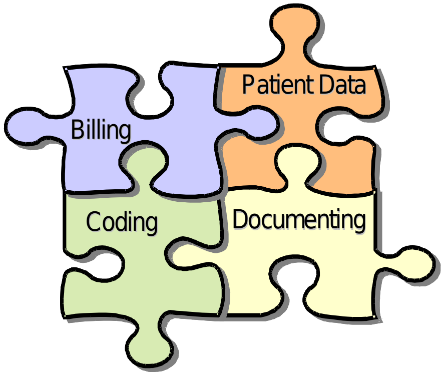
- Brief Review of the History of HIPAA
- Learn What’s Really Required by HIPAA & What’s Not
- Learn About the New HIPAA Requirements on the Horizon and their impact on the MHS
- Take Advantage of HIPAA Resources on the Internet
- Questions

How Did We Get Here?



- Move towards Standard Electronic Data Interchange (EDI) Transactions and away from paper-based processes
- Healthcare Industry pushing this effort in early 1990s
- Workgroup for EDI (WEDI) was taking the lead
  - Estimated $42 billion in net savings (1995-2000) - 1993 WEDI Report
- Recognize the Need to Protect Electronic Health Data
- Role of "Those Privacy Zealots"

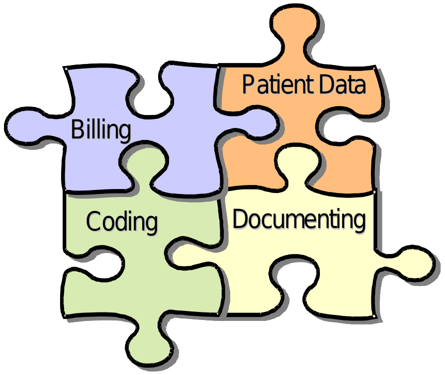
History of HIPAA



- Health Insurance Portability and Accountability Act (HIPAA) - P.L. 104-191
- Also known as Kennedy-Kassebaum Bill (K2) or Kassebaum-Kennedy depending upon your party affiliation
  - House of Representatives passed it 421-2
  - Senate passed it Unanimously
- Signed into law on August 21, 1996, by President Clinton

CORE COMPETENCIES

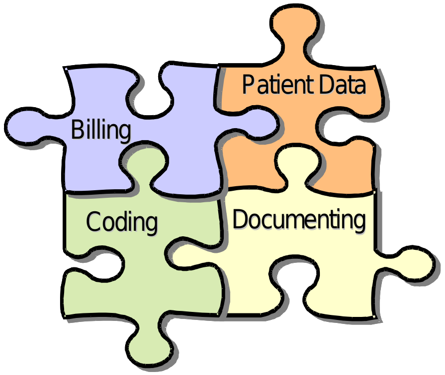
HIPAA Components


Patient Data
Billing
Coding
Documenting

- Insurance Portability
- Accountability (Fraud & Abuse)
- Administrative Simplification

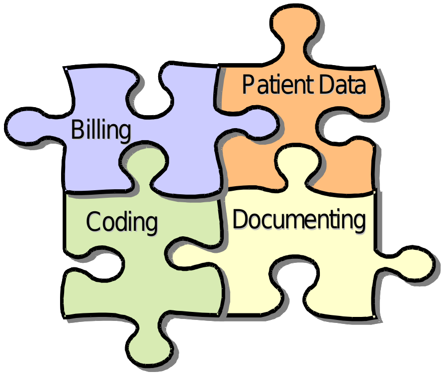
CORE COMPETENCIES

Key Intents of HIPAA Administrative Simplification


Billing
Patient Data
Coding
Documenting

- Reduce Paperwork
- Improve Efficiency of Health Systems
- Protect Security and Confidentiality of Electronic Health Information

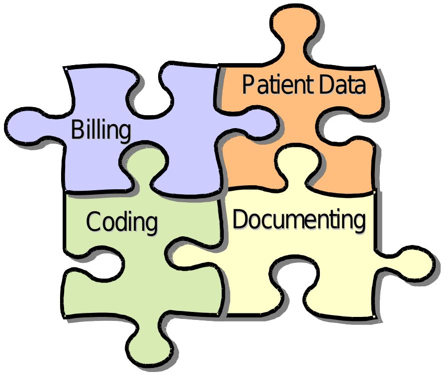
HIPAA Rule Making Process



- Department of Health & Human Services (DHHS) publishes Notice of Proposed Rule Making (NPRM)
- 60 Day Comment Period
  - Receive Written Public Input
- Comments reviewed resulting in modifications to the Final Rule version
- Final Rule published in Federal Register
- Congress has 60 Days to Make Changes
- Two years before Final Rule becomes effective
  - Normally

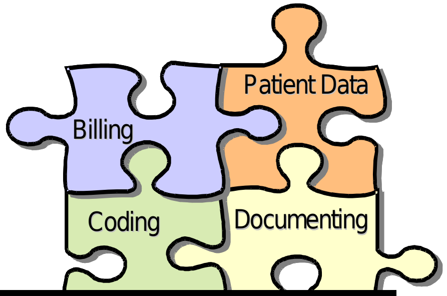
CORE COMPETENCIES

HIPAA's Original Timeline



- HIPAA signed into law on August 21, 1996
- All Final Rules to be issued by February 21, 1998
  - Eighteen months after signing into law
- Full compliance to be achieved by April 22, 2000
  - We've been under HIPAA for more than 4 years!!!
- What Happened?
  - DHHS had Three (3) Number One Priorities
    - Y2K
    - Balanced Budget Act (BBA) of 1997
    - HIPAA

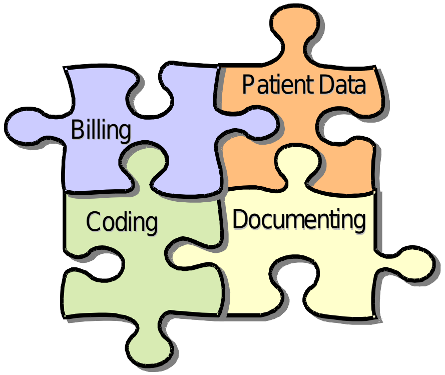
Timetable for Adoption of Standards



Standard	Notice of Proposed Rule Making (NPRM)	Final Rule Publication	Compliance Required
Transactions & Codes Sets	05/07/1998	08/17/2000	10/16/2003 - with extension
National Provider Identifier	05/07/1998	01/23/2004	05/23/2007 (2008<$5M)
National Employer Identifier	06/16/1998	05/31/2002	07/30/2004 (2005<$5M)
Security	08/12/1998	02/20/2003	04/20/2005 (2006<$5M)
Privacy	11/03/1999	12/28/2000	04/14/2003 (2004<$5M)

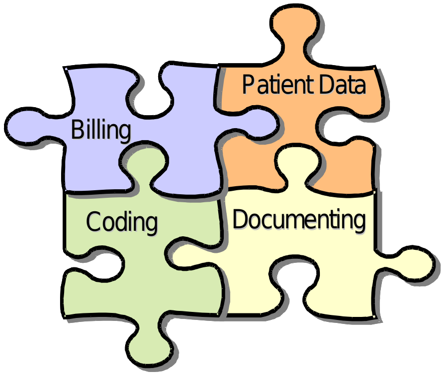
C O R E   C O M P E T E N C I E S

Who Must Use the Standards?



- Covered Entities (CEs) Include:
  - Health Plan
  - Health Care Clearinghouse
  - Health Care Provider (who transmits any health information in electronic form in connection with any covered transaction)
    - MHS Direct Care System is considered to be a Health Care Provider
- Congress directed DHHS to utilize existing standards wherever possible rather than developing new ones

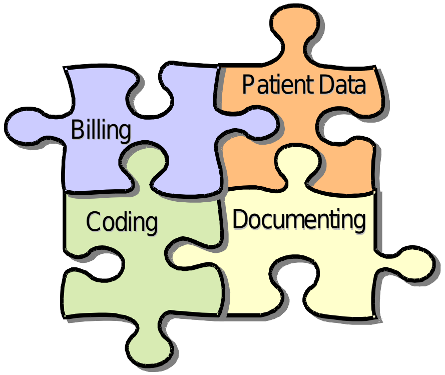
Civil & Criminal Penalties



- Civil penalty of $100 per violation, up to $25,000 maximum per year per HIPAA standard
- Wrongful Disclosure of Individually Identifiable Health Information (IIHI)
  - Fined not more than $50,000, imprisoned not more than 1 year, or both
- If offense committed under false pretenses
  - Fined not more than $100,000, imprisoned not more than 5 years, or both
- If offense committed with intent to sell, transfer, or use information for commercial advantage, personal gain, or malicious harm
  - Fined not more than $250,000, imprisoned not more than 10 years, or both

CORE COMPETENCIES

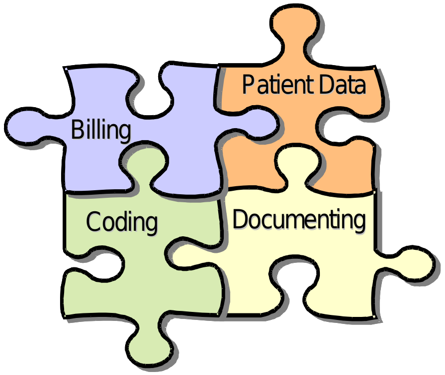
ANSI ASC X12N &IGs



- ANSI – American National Standards Institute
- ASC X12 – Accredited Standards Committee chartered by ANSI to develop standards for inter-industry electronic business transactions (EDI)
- X12N – is the Subcommittee for Insurance who developed the HIPAA EDI standards
- IGs – Implementation Guides that provide detailed formats for implementing the HIPAA EDI standards
- Version 4010A of the HIPAA IGs is the standard
- National Council for Prescription Drug Programs (NCPDP) developed standards for retail pharmacy drug claims

CORE COMPETENCIES

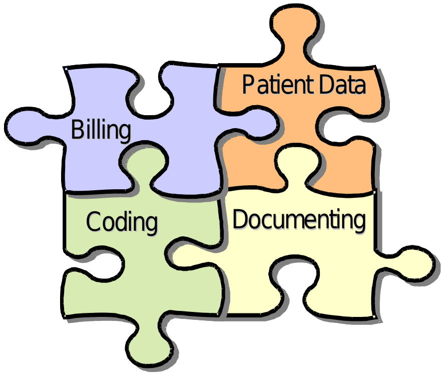
Covered Transactions



- 837 - Health Care Claim (3 types)
  - Institutional
  - Professional
  - Dental
- Retail Pharmacy Drug Claim
  - National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide, Version 5.1, September 1999
  - NCPDP Batch Standard Batch Implementation Guide, Version 1.1, January 2000

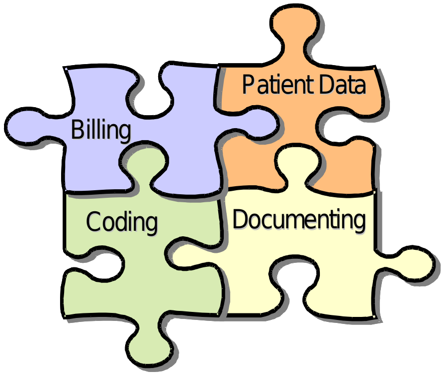
CORE COMPETENCIES

Covered Transactions (con’t)



- 270/271 - Health Care Eligibility Benefit Inquiry and Response
- 276/277 - Health Care Claim Status Request and Response
- 278 - Health Care Services Review
- 820 - Payroll Deducted and Other Group Premium Payment for Insurance Products
- 834 - Benefit Enrollment and Maintenance
- 835 - Health Care Claim Payment/Advice
- 837 - Coordination of Benefits

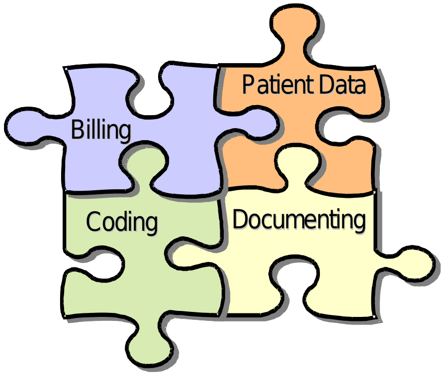
Mandated Code Sets



- ICD-9-CM – International Classification of Diseases – Clinical Modification for Diagnoses, 9th Edition (Volumes 1 and 2)
- ICD-9-CM - International Classification of Diseases – Clinical Modification for Inpatient Procedures, 9th Edition (Volume 3)
- CPT-4 – Current Procedural Terminology, 4th Edition
- CDT-3 – Code on Dental Procedures and Nomenclature, 3rd Edition
- HCPCS – Healthcare Common Procedure Coding System
- NDC – National Drug Codes – were to replace HCPCS J-codes
  - NPRM/Final Rule issued to modify this requirement for non-retail pharmacies & hospitals

CORE COMPETENCIES

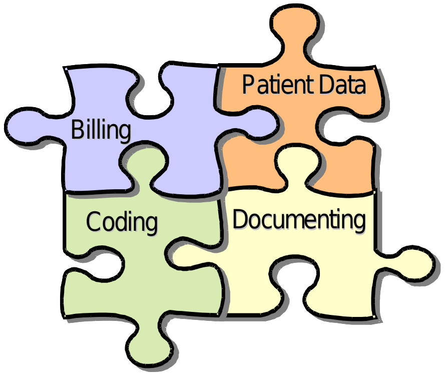
Impact of HIPAA EDI



- Electronic claims just means faster rejections if data is incomplete or incorrect
- Increasing emphasis on the need for quality data “the first time”
- Personnel savings may need to be redeployed to other areas in order to improve data capture and quality
- 837 is NOT an electronic UB-92 or CMS-1500
- HIPAA transactions often require more data that is currently captured or stored
- State Prompt Payment laws will still be needed
- Electronic claims attachments (275) will be a big aid once they are available

CORE COMPETENCIES

Benefits of a HIPAA EDI Case Study



- Allina Health System Projected Net Savings
  - $45 million over 5 years
    - Reduced A/R Days
    - Reduced FTE staffing doing Billing & Follow-up
- Calculate your Return on Investment (ROI) from moving to EDI
  - Exploit opportunities for re-engineering
  - Gain a competitive advantage
  - Help pay for Privacy & Security

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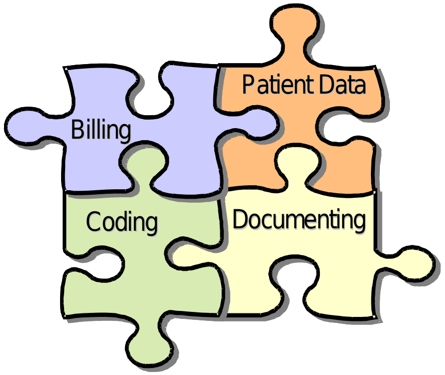
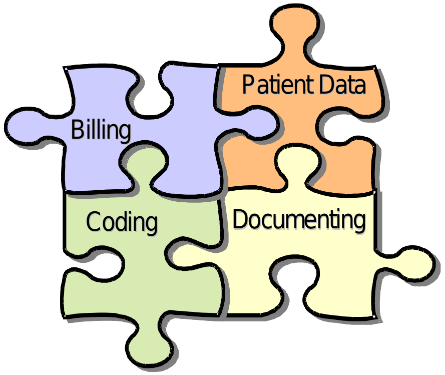
Privacy vs. Security



- Privacy - What Needs to Be Protected
  - Protected Health Information (PHI)
- Security - Methods by Which We Will Protect It
- Need to determine the desired balance among:
  - **C**onfidentiality of the Data
  - **I**ntegrity of the Data
  - **A**vailability of the Data
- Final Rules for Privacy issued December 2000 and August 2002
- Security Final Rule issued February 2003

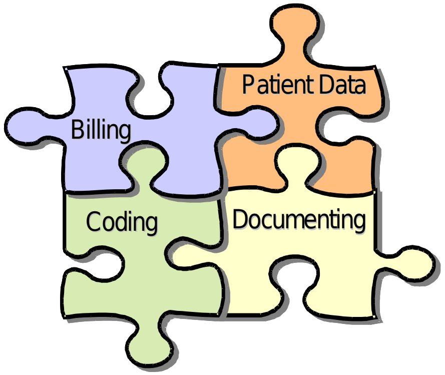
Privacy Rule



- December 2000 Privacy Rule required patients to give consent before their protected health information (PHI) could be used for treatment, payment, or health care operations (TPO)
- August 2002 Privacy Rule dropped the consent requirement
  - Direct health care provider now just has to make a *good faith effort* to obtain an individual’s written acknowledgement of receipt of the provider’s Notice of Privacy Practices (NPP)
  - Copy of MHS NPP on TMA HIPAA Web Site

CORE COMPETENCIES

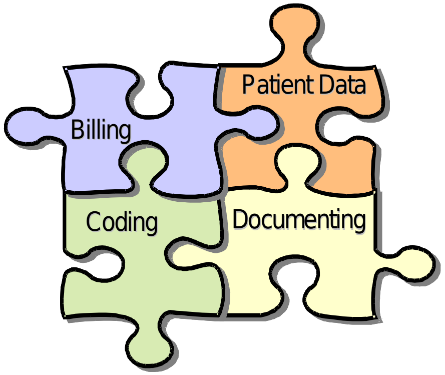
Privacy Rule (con’t)



- Authorization by the individual is still required before a Covered Entity can release PHI for non-TPO purposes
  - Life insurance company seeking medical information regarding a policy applicant
- Access without written authorization allowed for national and public health needs

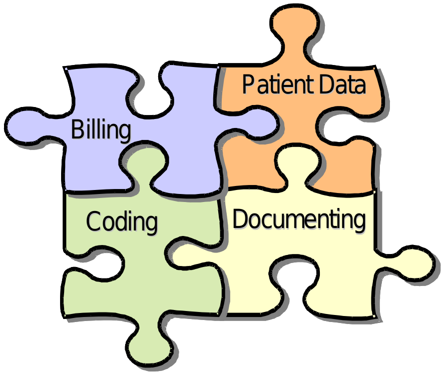
C O R E C O M P E T E N C I E S

Privacy Rule (con't)



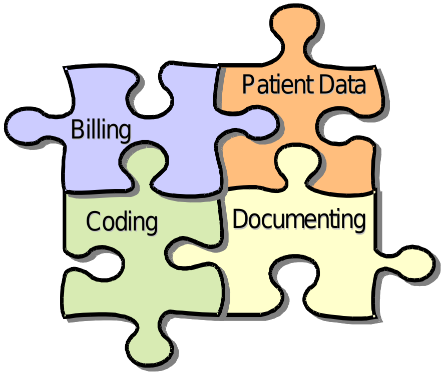
- Individual's right of access
  - Patient can see their medical record
  - Can request copies
  - Can request amendments to medical record
    - Provider does not have to make the amendment
- Preemption - Final Rule can not supercede more stringent State privacy laws
  - Establishes the Federal floor of safeguards
  - You need to know which State privacy laws still apply (i.e., those that are more stringent)

What Is IIHI?



- Individually identifiable health information (IIHI) is information that is a subset of health information, including demographic information collected from an individual, and:
  - Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
  - Relates to:
    - the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for health care received by an individual; and that
  - Either identifies the individual or provides a “reasonable basis” to believe the information can identify the individual

CORE COMPETENCIES

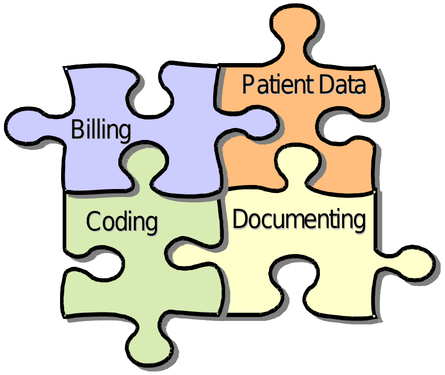


What is PHI?

- Protected Health Information (PHI) is IIHI that is:
  - Transmitted by electronic media; or
  - Maintained by electronic media; or
  - Transmitted or maintained in any other form or medium (includes written or oral communications)
- PHI excludes IIHI in:
  - Education records covered by the Family Educational Rights and Privacy Act (FERPA)
  - Employment records held by a CE in its role as an employer

CORE COMPETENCIES

Common HIPAA Privacy Myths



- Complex Privacy Rule is 1500 pages long
- New sound-proof walls and offices will have to be built. No more semi-private rooms allowed.
- You won’t be able to pick up your spouse’s prescription from the pharmacy
- Medical students won’t be allowed to see a patient’s entire medical record.
- Patients will be able to demand that physicians change their medical records

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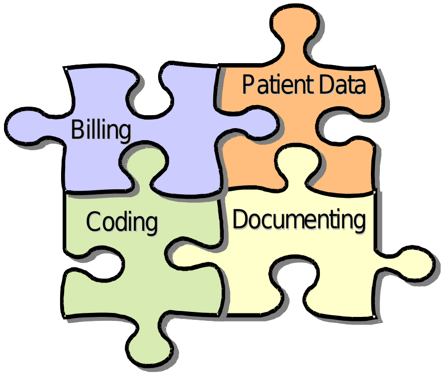
Real World Privacy Issues



- “Anonymous” medical records identified in Massachusetts
  - Governor’s record included
- Survey finds one out of six patients engage in “privacy protected behaviors”
- Foreign transcriber threatens California medical center to release medical records on the Internet
  - Disagreement over back pay

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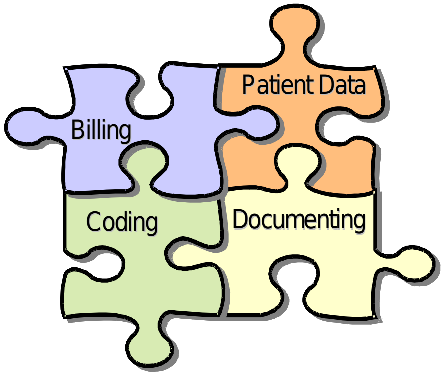
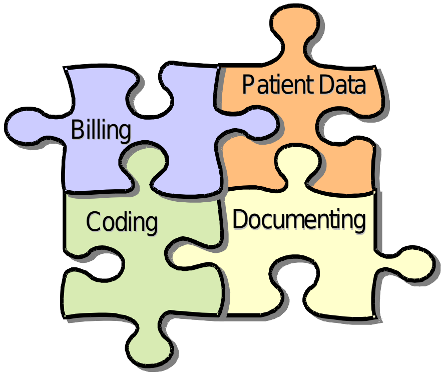
HIPAA Security Rule Background



- Proposed Rule was issued August 12, 1998 covering Security and Electronic Signature Standards (39 pages)
- Many Security and Privacy Recommendations Based on the National Research Council’s 1997 report entitled *For The Record: Protecting Electronic Health Information*
- More than 2,300 comments submitted by individuals and organizations

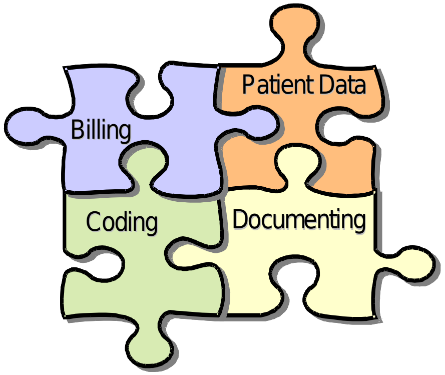
Background (con’t)



- Security Final Rule issued February 20, 2003 (48 pages)
  - Provisions apply **ONLY to electronic** Protected Health Information (PHI)
  - Does not cover electronic signatures
    - DHHS will issue separate NPRM/awaiting recommendation from NCVHS/date unknown
- Security Final Rule does not reference or advocate specific technology

CORE COMPETENCIES

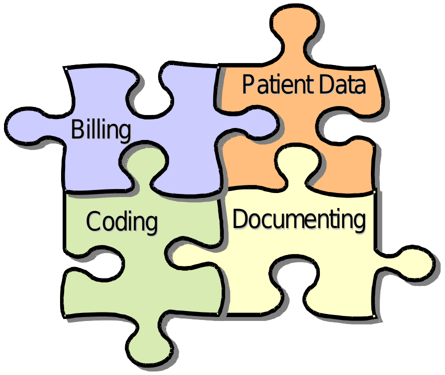
Background (con’t)



- Intentionally generic, scalable for both small and large organizations, technology neutral
- Each affected entity must assess its own security needs and risks and devise, implement, and maintain appropriate security measures to address its business requirements
- Measures must be **documented** and **kept current**
- Challenge for the organization to assess their own security risks, weigh them, implement appropriate solutions

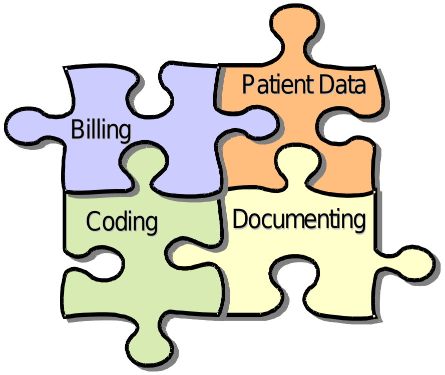
CORE COMPETENCIES

Security Standards – General Rules



- General Requirements – Covered Entities (CEs) must do the following:
  - Ensure the confidentiality, integrity, and availability of all electronic PHI the CE creates, receives, maintains, or transmits
  - Protect against any **reasonably anticipated** threats or hazards to the security or integrity of such information
  - Protect against any **reasonably anticipated** uses or disclosures of such information
  - Ensure compliance by its workforce

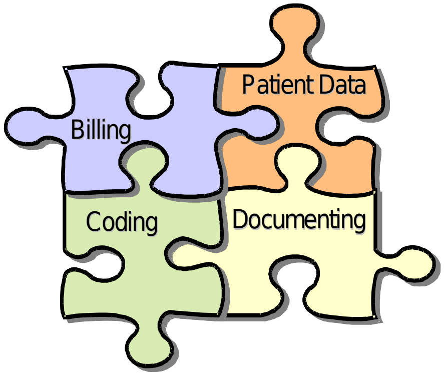
Some Operational Challenges



- Healthcare staff want to help others
  - We’re too trusting
- Security system is only as good as its weakest link
  - 999 secure passwords out of 1000 users is NOT “good enough”
- Hackers & Social Engineering
  - Attempt to exploit our desire to be helpful
  - Not enough to thwart them - need to report it to the right person so appropriate actions can be taken

CORE COMPETENCIES

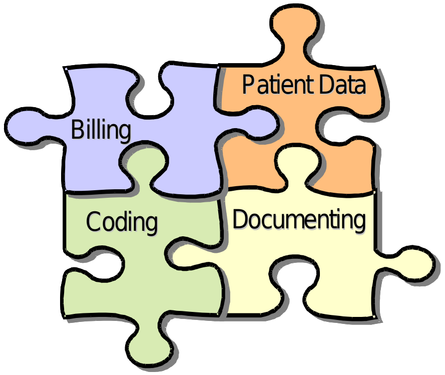
Some Operational Challenges (con’t)


Patient Data
Billing
Coding
Documenting

- Don’t be a Soft Target
  - Hackers are lazy
- Viruses and Worms
  - Need to be alert/wary
- Capability to track access to Protected Health Information (PHI)
  - Insurance Company example
  - Harvard Community Health Plan
    - Patients can review who accessed their PHI

CORE COMPETENCIES

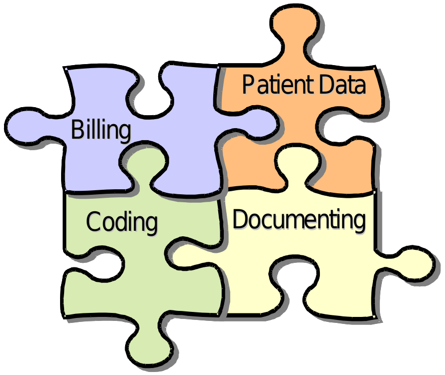
HIPAA Security Considerations


Patient Data
Billing
Coding
Documenting

- How do you dispose of your obsolete PCs?
  - Savannah River DOE example
  - Indianapolis hospital example
- Do you allow providers to access your network from their home PCs?
  - Any penalties for violations?
  - Are they ever enforced?

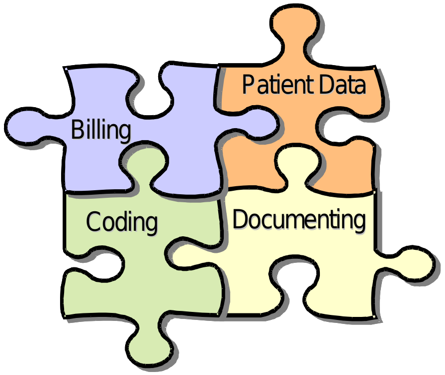
CORE COMPETENCIES

HIPAA Security Considerations (con’t)



- Have you outsourced medical transcription? If so, how is PHI transmitted/stored & protected when off-site?
- Do your passwords contain both alpha and numeric characters as well as special characters/minimum length of at least 8 characters
  - How often are they updated?
  - No Yellow Post-Its on the PC Monitor or under the keyboard

New Requirements on the Horizon



- National Provider Identifier (NPI)
  - Health care providers may begin applying for an NPI beginning May 23, 2005
  - Health care providers, health plans, and health care clearinghouses must begin using the NPI in standard transactions NLT May 23, 2007
    - Small health plans have until NLT May 23, 2008
  - 10-position numeric identifier (last digit is a check figure)
  - Intelligence-free number
  - NPI Entity Type Code 1 – for health care providers who are individual human beings
  - NPI Entity Type Code 2 – for health care organizations

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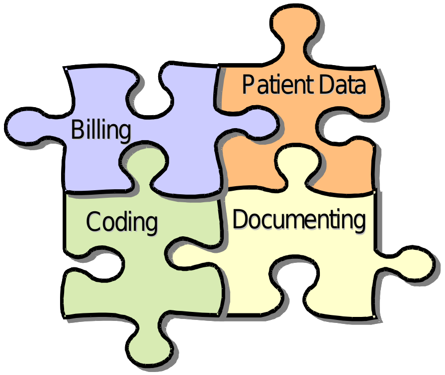
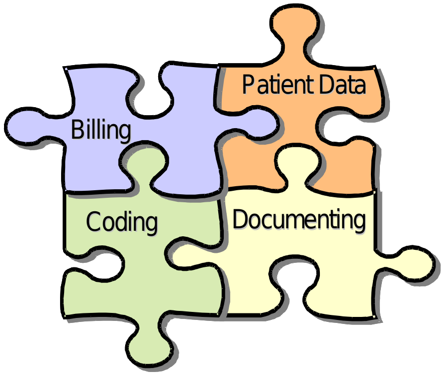
Use of the NPI in the MHS



- HA Policy 05-002 issued 26 January 2005 regarding NPI Entity – Type 1
  - Requires "all Health Care Providers who furnish billable health care services or who may initiate and/or receive referrals must obtain an NPI-Type 1."
  - Services are responsible for ensuring all privileged/credentialed providers (including reservists) obtain and submit their NPI to the TMA designated data base/repository prior to 23 May 2007
  - Services SGs will issue Memoranda of Instruction detailing Service-specific instructions
- Policy letter for Type 2 under development

CORE COMPETENCIES

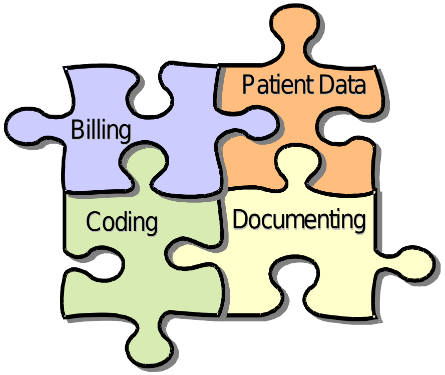
New Requirements on the Horizon (con't)



- New UB-04 Form replacing UB-92 in 2007
- New revised CMS-1500 Form coming in 2007
  - Both New forms will require use of NPIs
- MHS System Change Requests (SCRs) being developed for implementation to support new paper claim formats
- ICD-10s likely coming in 2007-2008 timeframe(?)
- TMA monitoring status of ICD-10 implementation in U.S.
  - Changes will be made in MHS automatedinformaton systems to support the new code set once it is mandated

CORE COMPETENCIES

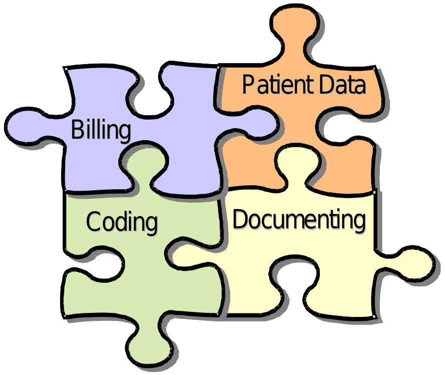
Truisms Regarding HIPAA Compliance



- Changing the Organizational Privacy & Security Culture will be the BIGGEST Challenge
- HIPAA Compliance has No Finish Line
  - NCVHS recommended in February 2002 more clinical messaging formats as potential HIPAA standards for an electronic medial record (EMR)
  - New Transaction Sets will be added (e.g., 275)
  - ICD-10s likely coming in 2007-2008 timeframe(?)
  - New UB-04 Form replacing UB-92 in 2007
  - New CMS-1500 Form using NPI coming in 2007

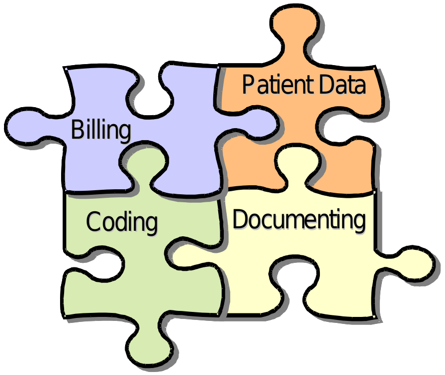
CORE COMPETENCIES

HIPAA Resources on the Internet



- TMA HIPAA Web site
  - http://www.tricare.osd.mil/hipaa/
- TMA UBO HIPAA Web site
  - http://tricare.osd.mil/rm/ubo_hipaa.cfm
- HA Policy 05-002 - NPI Entity – Type 1
  - http://www.ha.osd.mil/policies/
- UB-04 Draft Claim Form
  - http://www.nubc.org/new.html
- CMS-1500 Draft Claim Form with NPI
  - http://www.nucc.org/Draft1500
- CMS HIPAA Web site
  - http://cms.hhs.gov/hipaa/hipaa2

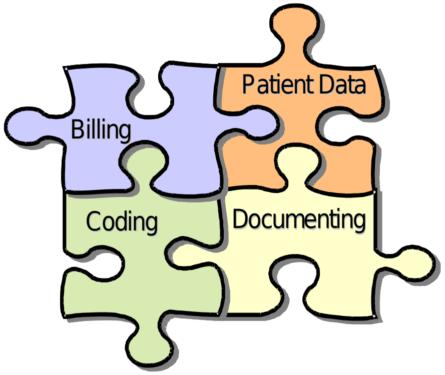
HIPAA Resources on the Internet (con’t)



- DHHS Office of Civil Rights (OCR)
  - http://www.hhs.gov/ocr/hipaa
- For the Record: Protecting Electronic Health Information The National Academies Press, 1997 -
  - http://www.nap.edu or 1-800-624-6242
- View Free On-line Version of For the Record
  - http://books.nap.edu/books/0309056977/html/index.html
- Washington Publishing Company - HIPAA EDI Implementation Guides
  - http://www.wpc-edi.com/hipaa/HIPAA_40.asp
- Workgroup for Electronic Data Interchange (WEDI)
  - http://www.wedi.org

CORE COMPETENCIES

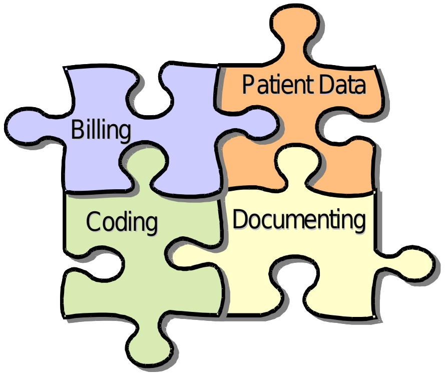
HIPAA Resources on the Internet (con't)



- Strategic National Implementation Process (SNIP)
  - http://snip.wedi.org
- National Council for Prescription Drug Programs (NCPDP)
  - http://www.ncpdp.org
- National Institutes of Health (NIH)
  - http://privacyruleandresearch.nih.gov/
- Health Privacy Project
  - http://www.healthprivacy.org
- Writing HIPAA NPPs in Plain English
  - http://www.hrsa.gov/language.htm#appendix_D

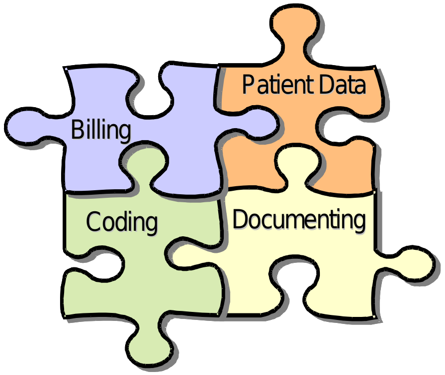
CORE COMPETENCIES

HIPAA Resources on the Internet (con’t)



- Guidelines for Academic Medical Centers on Security and Privacy
  - http://www.aamc.org/members/gir/gasp
- Centers for Medicare & Medicaid Services (CMS) Information Security
  - http://cms.hhs.gov/it/security/default.asp
- National Institute of Standards & Technology (NIST) Computer Security Resource Center (CSRC)
  - http://csrc.nist.gov

HIPAA Resources on the Internet (con’t)



- CPRI Toolkit for Health Care Security Management, Version 4
  - http://www.himss.org/ASP/topics_cpriToolkit.asp?faid=74&tid=5
- California HealthCare Foundation
  - http://www.chcf.org/
- Massachusetts Health Data Consortium
  - http://www.mahealthdata.org
- North Carolina Healthcare Information & Communications Alliance (NCHICA)
  - http://www.nchica.org/

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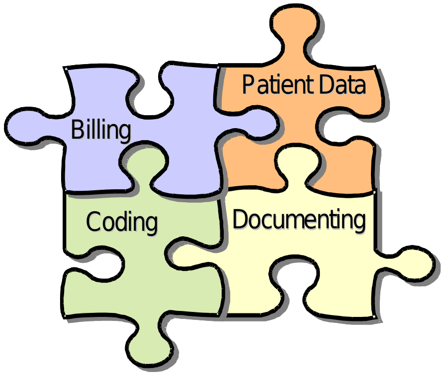
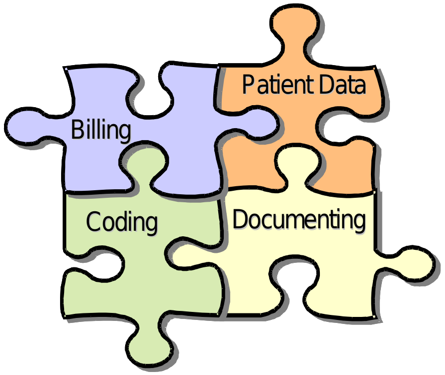
Summary



- History of HIPAA
  - It’s Been a Law since 1996!
- What’s Really Required by HIPAA & What’s Not
  - Need to separate Truth from Fiction
- New HIPAA Requirements on the Horizon
  - NPIs, new forms (UB-04, CMS-1500). ICD-10, New Transactions (275)
- Take Advantage of HIPAA Resources on the Internet
  - No Need to “Reinvent the Wheel!”

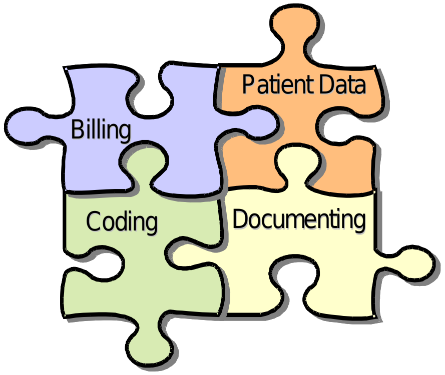
Speaker Contact Information


Billing
Patient Data
Coding
Documenting

Tom Sadauskas, FHFMA, CHE, CPA
Deputy Program Manager
Uniform Business Office
TRICARE Management Activity

703-681-3492 x4069
thomas.sadauskas@tma.osd.mil

CORE COMPETENCIES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Coding
Documenting

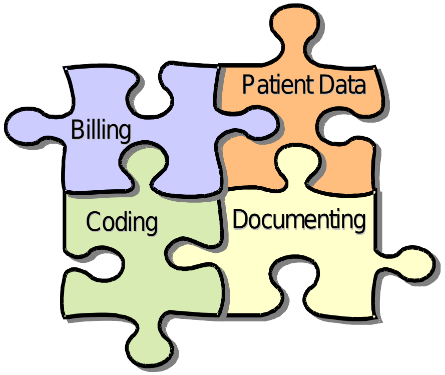
Ambulatory Procedure Visit (APV) Billing for the MHS in 2005

You bring your Solutions and Issues

Tuesday, 17 May 2005, 1300

Track 4, UBO

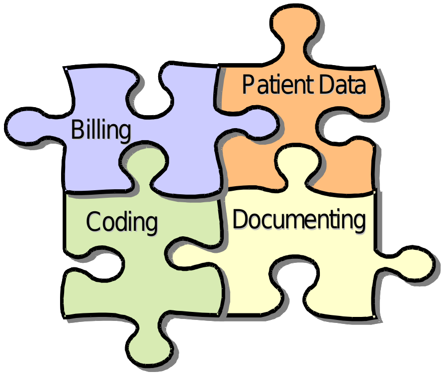
Objectives



- Understand how the civilian sector bills (and where we are headed)
- Know how ambulatory procedure visit (APV) **professional** services are currently billed
- Know how APV **institutional** services are currently billed
- Understand why we don’t currently bill separately for inpatient surgeries

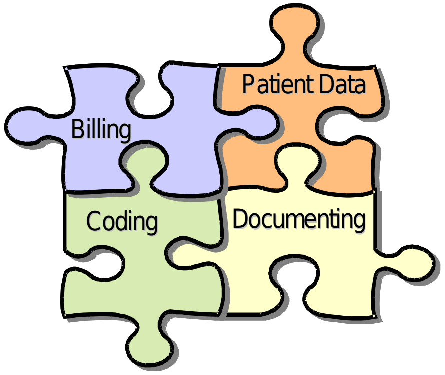
CORE COMPETENCIES

Civilian Sector


Patient Data
Billing
Coding
Documenting

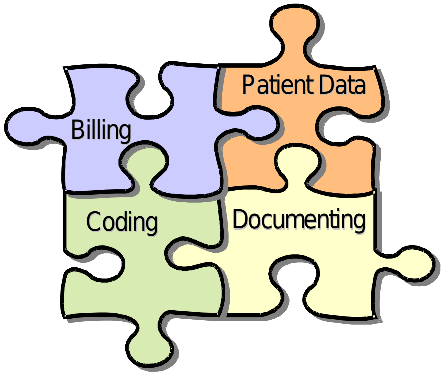
- Generally, the professional component and institutional components are not provided by the same organization.
- Professional Institutional

Civilian Sector Professional Billing



- CMS 1500
- One bill for professional services (e.g., doctor’s bill) for entire episode of care, from the pre-operative, the procedure and post operative care (global code)
- One bill from the anesthesiology practice (may have two line items, one for supervision/direction and one for actual provision)
- Possible separate bill from pathologist or radiologist

Civilian Sector APV Institutional Billing

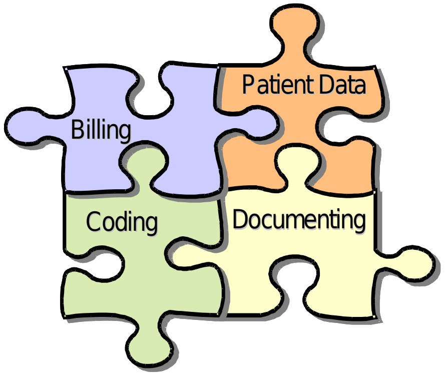


HCPCS Code	Short Descriptor	ASC Payment Group	Payment Amount
23570	Treat shoulder blade fx	1	333
23575	Treat shoulder blade fx	1	333
23585	Treat scapula fracture	3	510
23600	Treat humerus fracture	1	333
23605	Treat humerus fracture	2	446
23615	**Treat humerus fracture**	**4**	**630**
23616	Treat humerus fracture	4	630
23620	Treat humerus fracture	1	333
23625	Treat humerus fracture	2	446
23630	Treat humerus fracture	5	717
23650	Treat shoulder dislocation	1	333

Institutional billing is based on the ASC with the revenue code indicating the place of service.

CORE COMPETENCIES

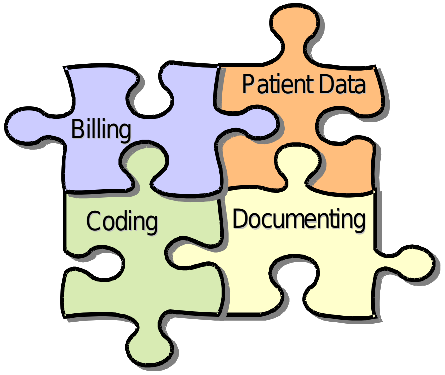
Civilian Sector Institutional Billing


Patient Data
Billing
Coding
Documenting

- UB 92
- Ambulatory Payment Classifications (APCs)
  - APCs based on the CPT procedure done
- Ambulatory Surgery Center Payment Groups
- Revenue Codes
- Possibly separate bills from laboratories and diagnostic imaging centers

C O R E C O M P E T E N C I E S

Military Health System (MHS) APV Billing

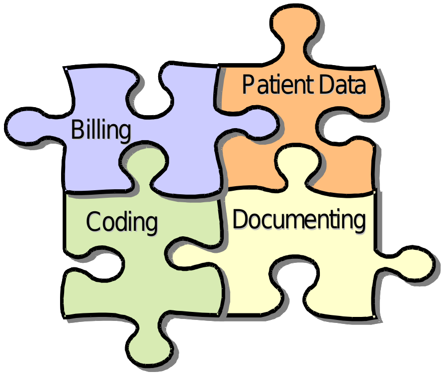

Patient Data
Billing
Coding
Documenting

- Surgeon’s bill
- Anesthesia bill (if not furnished by surgeon)
- Institutional bill

- Currently, only one coded encounter, so all three components on one episode feed
- Need to generate separate bill for each component

CORE COMPETENCIES

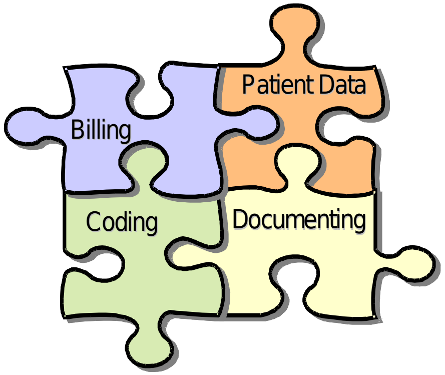
Military Health System (MHS) APV Billing



- Back out “composite” bill which would have the institutional (99199) mixed with the surgeons (e.g., 1xxxx-6xxxx) and the anesthesia (0xxxx)
- Manually generate three separate bills
  - 1 for the surgeon, assistant at surgery
  - 1 for the anesthesia
  - 1 for the institutional

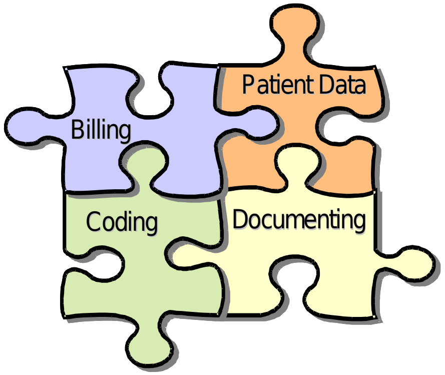
CORE COMPETENCIES

APVs admitted to the hospital



- When a patient is admitted after an APV, prior to the patient being discharged from the APV, there should be NO APV bills.
  - The entire procedure, both institutional and professional becomes part of the inpatient care
  - The bill will be based on the Diagnosis Related Group (DRG)

APVs admitted to the hospital (continued)



- Rationale:
  - The APV was done at the MTF so the institutional component was done at the MTF
  - The Diagnosis Related Group includes the institutional component for the APV surgery and the follow-up complications
  - In the MHS, the professional components (surgeon and anesthesia) are included in the Adjusted Standardized Amount

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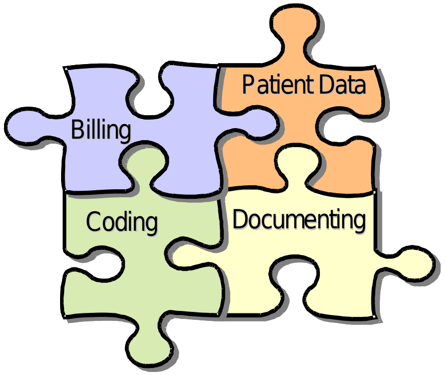
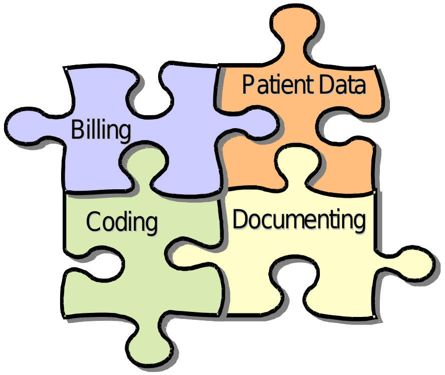
APVs admitted to the hospital (continued)


Patient Data
Billing
Coding
Documenting

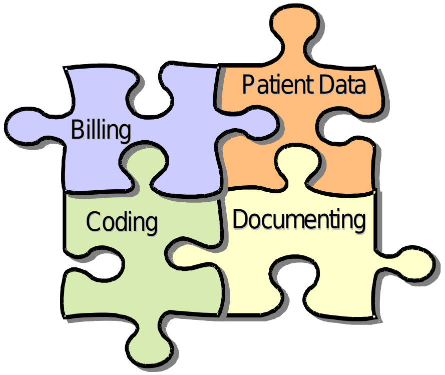
- Rationale:
  - The Adjusted Standardized Amount is multiplied by the Relative Weighted Product (RWP) to generate the inpatient bill

MHS Emergency Room encounter with direct admission to the Hospital



- In the MHS billing system, only one fee may be attached to a code
  - For example, 99281, ER visit, limited may only have one fee
  - This is why we use the 99199 to reflect the institutional portion of the APV
- The current ER bill, is a combination of
  - The MTF institutional cost and
  - The ER professional cost
  - The institutional component is greater than the professional cost, which is why it is billed on the UB 92
- When a patient comes to the hospital for a heart attack, whether the patient spends his first hours in the ER, or the Intensive Care Unit (ICU), the institutional component is part of the Diagnosis Related Group.

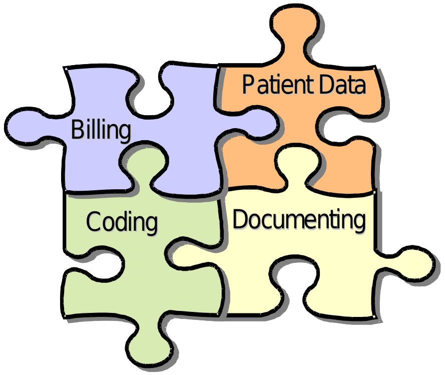
MHS Emergency Room encounter with direct admission to the Hospital



- So, if a patient presents to the ER, and is a direct admission, will the ER institutional be a separate bill? NO
- If the ER bill is a combination of the professional and institutional components, can you bill it? NO
- The INSTITUTIONAL component of the ER visit, becomes part of the hospitalization.
- The E&M services of the admitting provider are part of the hospitalization
- What can’t be billed? The ER professional service component.

CORE COMPETENCIES

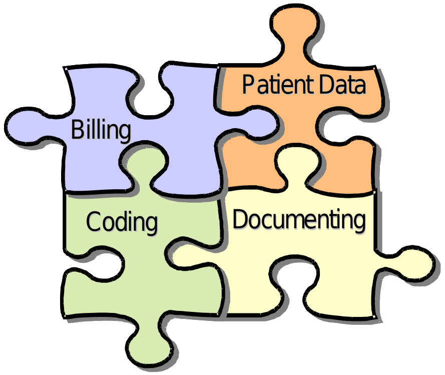
MHS Observation encounter with direct admission to the Hospital



- What do you think?
- Hint:
  - There is only one code for an observation encounter.
  - The MHS billing system can only have one price for a code
  - Observation has both an institutional and professional component, usually done by separate entities in the civilian sector

CORE COMPETENCIES

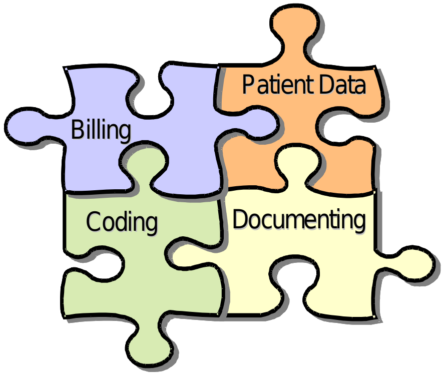
MHS Observation encounter with direct admission to the Hospital


Billing
Patient Data
Coding
Documenting

- RIGHT – you can’t bill for observation if the observation patient is admitted to the hospital

CORE COMPETENCIES

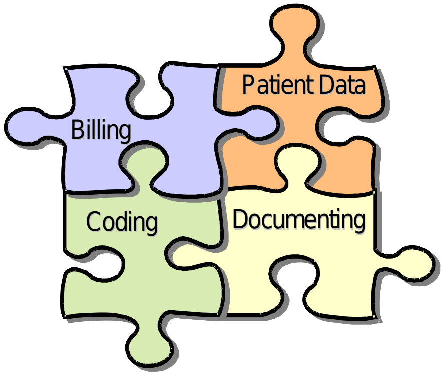
What about doctor’s office visits directly admitted to the hospital?



- Right, you should not bill for the doctor’s office visit.
- Why? Because the professional component of the outpatient visit becomes part of the admission E&M.
- In the MHS, the professional component of the hospitalization is included in the ASA calculation. The ASA is multiplied by the RWP to generate the hospital bill.

CORE COMPETENCIES

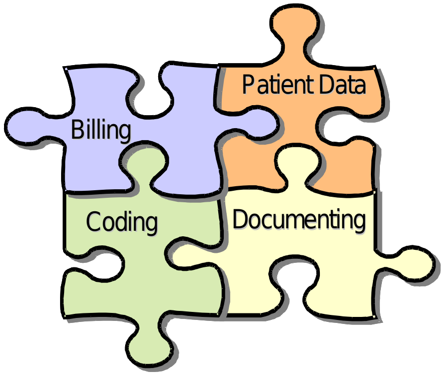
Civilian Sector Billing for Cosmetic Surgery


Patient Data
Billing
Coding
Documenting

- Insurance companies not involved
- Patient negotiates directly with the cosmetic surgeon/dermatologist
- Patient pays the cosmetic surgeon / dermatologist on whatever plan is agreed

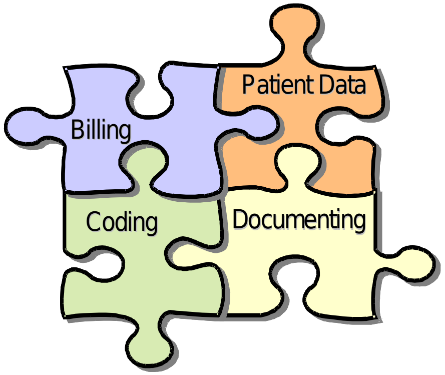
CORE COMPETENCIES

Cosmetic Surgery, until the new rate table (hopefully in July or August 2005)…



- Flat rate of CPT professional component x 2 for outpatient procedures
  - Includes institutional component of APV and office visit
  - Includes anesthesia component
- Billed in MSA module directly to patient using an Invoice & Receipt (I&R)

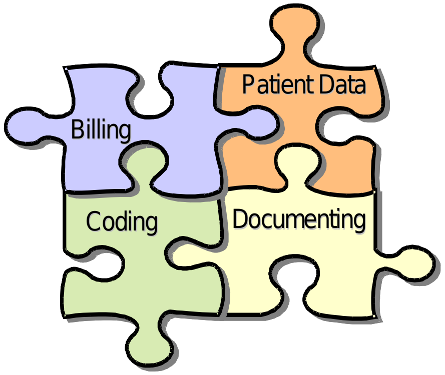
Cosmetic Surgery, with the new rate table (hopefully in July or August 2005)…



- The Surgeon’s pre-cosmetic surgery form will collect if there will be anesthesia
  - Enter the surgeon’s responses in the “Cosmetic Surgery Calculator Tool”
  - The tool is programmed to enter the usual amount of time for each cosmetic procedure
  - The total bill will include the surgeon’s services, the institutional fees, implant fees and anesthesia fees (so long as the data collection form is accurately completed)

CORE COMPETENCIES

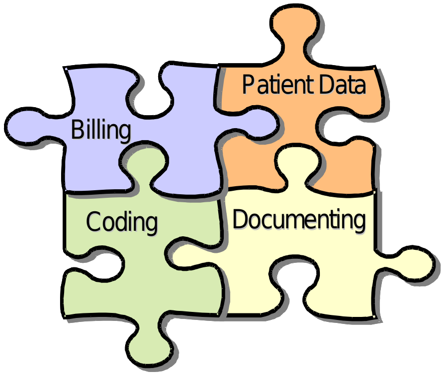
Why we don’t separately bill for inpatient surgical services



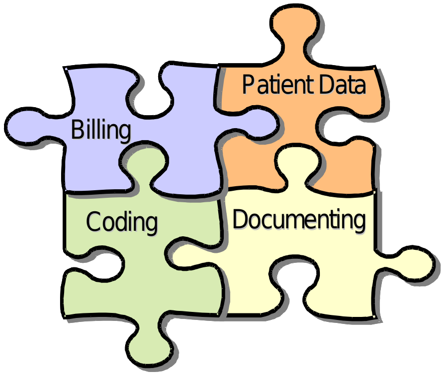
- Inpatient services are flat rate billed
- Based on Average Standardized Amount (ASA) for the MTF x the Relative Weighted Product (RWP) of the Diagnosis Related Group (DRG)
- 4% of the total fee is the professional component (surgeon and anesthesia provider’s time)

CORE COMPETENCIES

Summary


Patient Data
Billing
Coding
Documenting

- Civilian sector billing (and where we are headed)
- Ambulatory procedure visit (APV) **professional** services billing
- APV **institutional** services billing
- We don’t currently bill separately for inpatient surgeries


Patient Data
Billing
Coding
Documenting

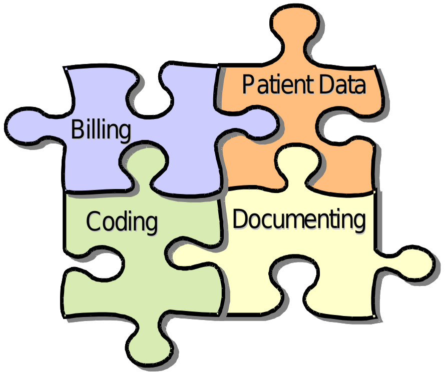
Denials 1

Preventing Denials
Clean Claims

Bonnie Severson
Tuesday, May 17, 2005
2:00 – 2:45
Track 4, UBO Advanced

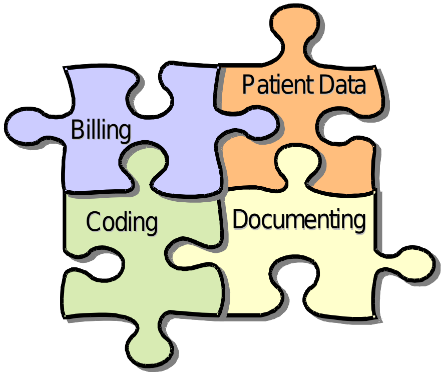
CORE COMPETENCIES

It’s a TEAM Effort


Patient Data
Billing
Coding
Documenting

- **Gathering of Patient Demographics**
- **CHCS Data Entry**
- **Provider Chart Documentation**
- **Record Coding General – Data Quality**
- **Ancillary Services Coding – Data Quality**
- **Coding Audits**
- **Provider Table Accuracy**
- **NDC Code Accuracy**

CORE COMPETENCIES

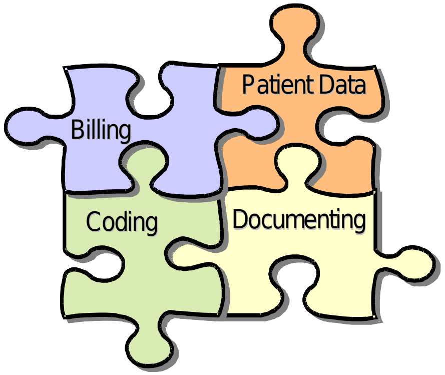


Patient Demographics

- **Patient Name**
- **Patient Date of Birth**
- **Patient Address**
- **Insured Individual Name**
- **Effective Dates – Term Date**
- **Copy of Patient Insurance ID CARD – COPY Front and Back**
- **Coverage Through? Employer/Retiree Plan**
- **Insurance Company Name**
- **Patient ---ID!!!**
- **Plan Code**
- **Insurance Address – RX vs. Medical**

CORE COMPETENCIES

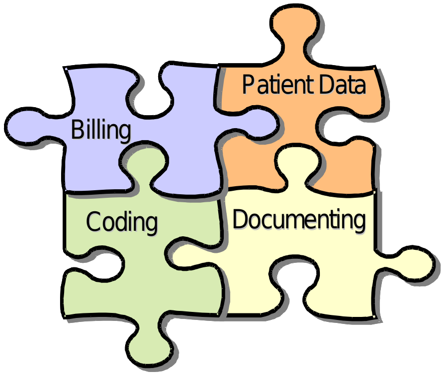
CHCS Data Entry


Patient Data
Billing
Coding
Documenting

- **Verified Information only**
- **RX vs. Medical Plans**
- **Occupational Visits – not billable – special MEPRS**
- **Accident Case**
  - Block 11 of DD Form -2569

CORE COMPETENCIES

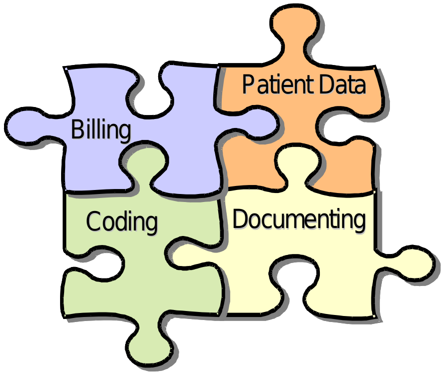
Documentation-Clinical


Patient Data
Billing
Coding
Documenting

- **Provider documentation of services rendered**
- **Audits**
- **Statistical reports**
- **Education and Training**

CORE COMPETENCIES

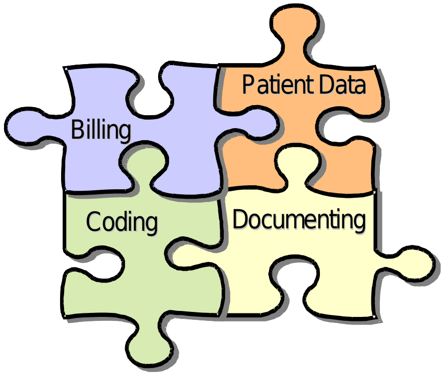
Coding - General


Patient Data
Billing
Coding
Documenting

- **Code only what is documented**
- **Audit and Educate**

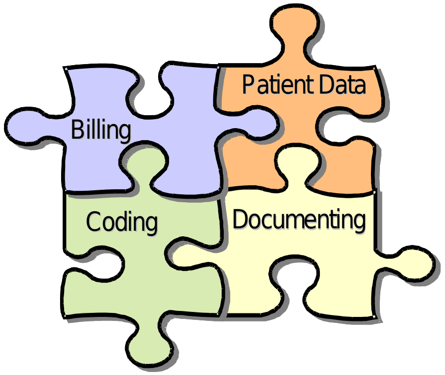
CORE COMPETENCIES

Coding Ancillary Services


Patient Data
Billing
Coding
Documenting

- **Be Specific**
- **Utilize data from Civilian Ordering Physician**
- **Reflect actual service not general**
- **CPT Code Book – Annually update**

CORE COMPETENCIES

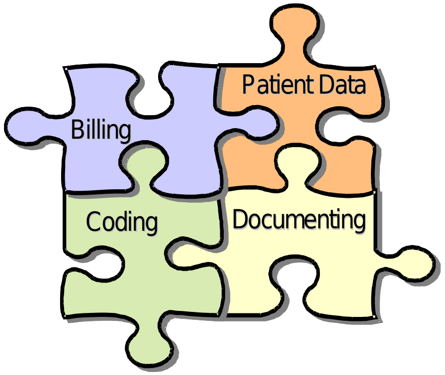

Patient Data
Billing
Coding
Documenting

Provider Tables

- **Specialty**
- **Non Privileged Provider vs. Privileged Provider**
- **DEA Codes**
- **License #'s**
- **HIPAA Taxonomy**

CORE COMPETENCIES

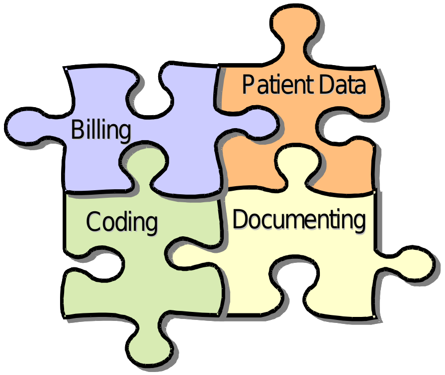
NDC #’s


Patient Data
Billing
Coding
Documenting

- **Frequency of Updates**
- **Ownership of Updates**
- **Expired items – Zero $’s – NO RATE**

CORE COMPETENCIES

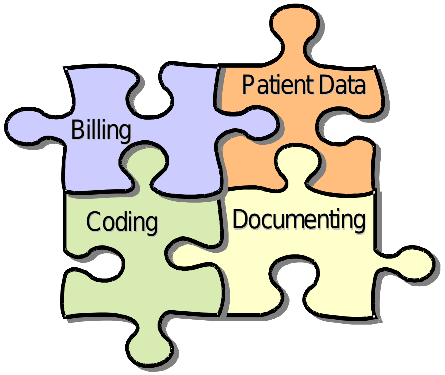
Most Frequent Denials


Patient Data
Billing
Coding
Documenting

- **Non Participating Provider**
- **Medicare EOB Required**

C O R E C O M P E T E N C I E S

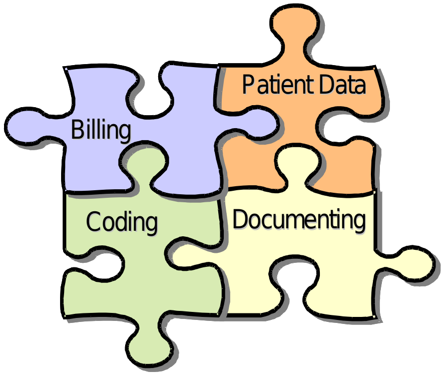
Front End Impact on Back End A/R Functions


Patient Data
Billing
Coding
Documenting

- **Incorrect data**
  - Cause payer denials
  - Cause claim rejections
  - Cause slow down in payment
  - Cause payers to question credibility of future claims

CORE COMPETENCIES

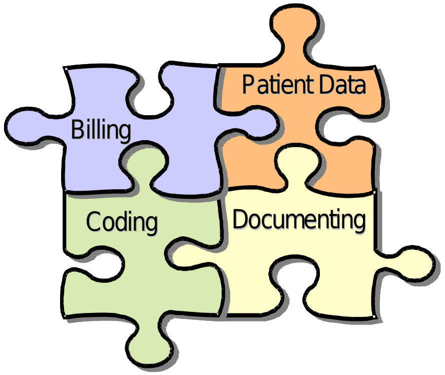
Front End Impact on Back End A/R Functions (con’t)


Patient Data
Billing
Coding
Documenting

- **Insufficient data**
  - Same as above
- **Staff frustrations**
- **Leadership questions**

CORE COMPETENCIES

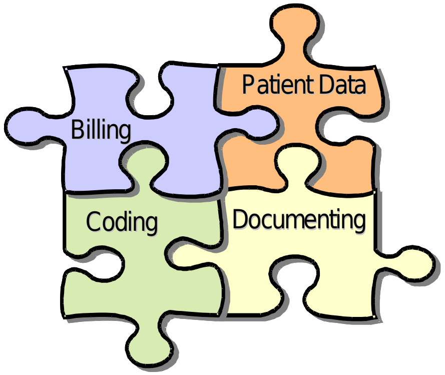
Front End Impact on Back End A/R Functions (con’t)


Patient Data
Billing
Coding
Documenting

- **Communicate and educate your partners**
  - Leadership
  - Providers
  - Check- In Personnel
  - Coders
  - UBO Office
  - Payers

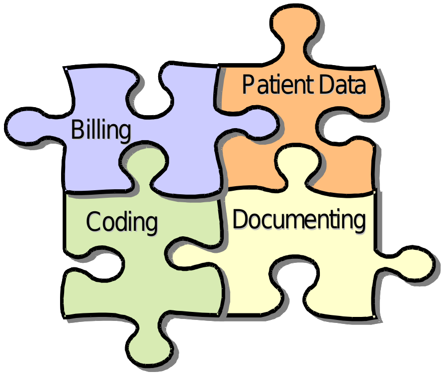
CORE COMPETENCIES

Front End Impact on Back End A/R Functions (con't)


Billing
Patient Data
Coding
Documenting

- Make suggestions
- Partner with your TPC staff
- Provide Briefings on outcomes and impacts
- Monitor when changes are to be made
- Provide Feedback on weakness and SUCCESS

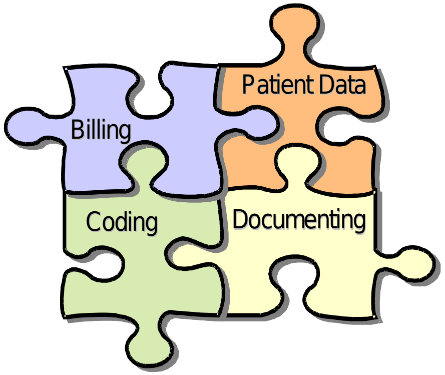
CORE COMPETENCIES


Patient Data
Billing
Coding
Documenting

Conclusion

QUESTIONS?

CORE COMPETENCIES


Patient Data
Billing
Coding
Documenting

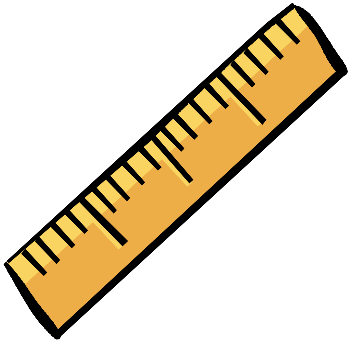
DENIALS MANAGEMENT II ‘DON’T BE PUZZLED BY THE RULE’

Bernadette Tabhan, Program Manager

Benefit Recovery

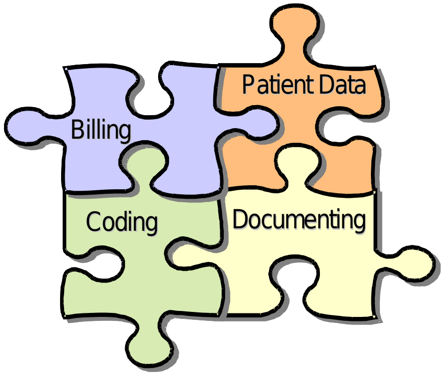
Tues, 17 May 2005

Track 4, UBO



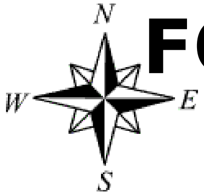
CORE COMPETENCIES

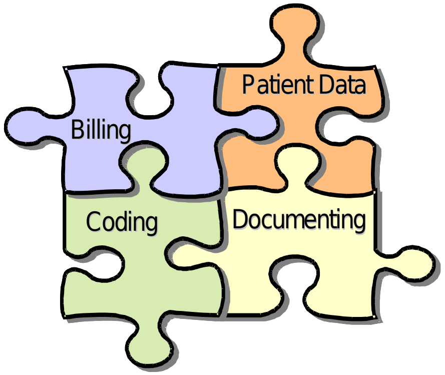
Objectives



- **HOW TO NAVIGATE REQUESTS FOR NEGOTIATION**
- **OUT OF NETWORK PAYMENTS BY PPO AND HMO CARRIERS AND WHAT THEY MEAN TO REVENUE**
- **CONTRACTS vs PREVAILING RATES – HOW TO APPLY 32 CFR AND 10 USC 1095**
- **RECOUPMENTS vs REFUND REQUESTS – HOW DO THEY GET AWAY WITH IT???**
- **WHAT IS THE SUNSET PROVISION OF 32 CFR 220.12**
- **WHEN TO USE THE BASE LEGAL DEPARTMENT**

NAVIGATING REQUESTS FOR NEGOTIATION



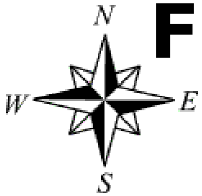


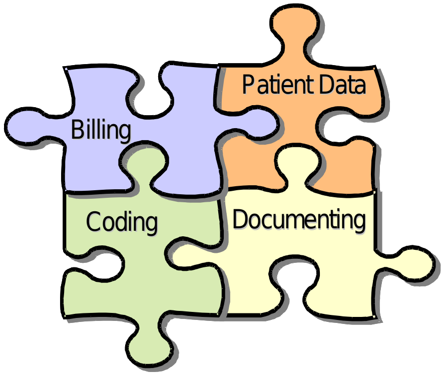
Carriers and pricing companies

- **Some carriers forward all non-contracted provider claims to pricing agencies such as Concentra, to reduce payment. Since the MTF is always considered non-contracted, claims are sent automatically.**
- **Carriers do this to wear down the provider in the hopes a contract can be negotiated. Since this does not apply to facilities of the Uniformed Services, carriers and pricing agencies should be notified that this practice is inappropriate**.

CORE COMPETENCIES

NAVIGATING REQUESTS FOR NEGOTIATION



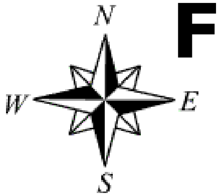


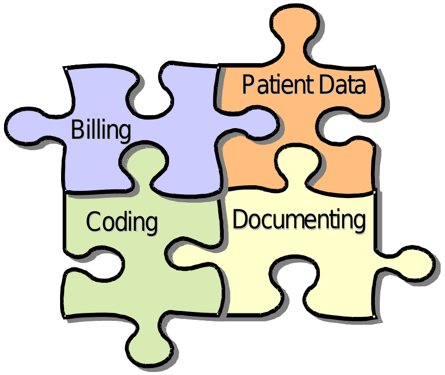
Tactics used by carriers to gain an agreement

- **Represent themselves as nurses, physicians or attorneys, claiming the need to discuss the claim for medical necessity reasons, and turn the discussion to rate negotiation.**
- **Request a separate signature for payment to be released, and/or term their process as “Verification of charges for prompt payment”.**
- **Call other members of your team to attempt an authorization for a reduced payment.**
- **Fax a request for reduction simply by asking for your fax number and claiming a response is required for payment**

CORE COMPETENCIES

NAVIGATING REQUESTS FOR NEGOTIATION



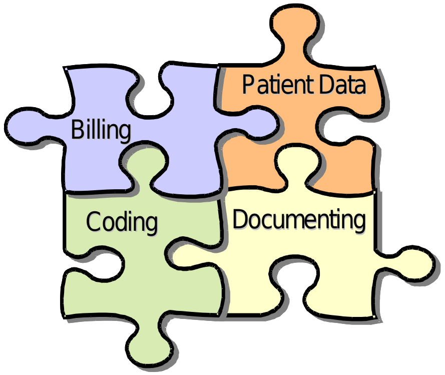


Tips for denials management of negotiation requests

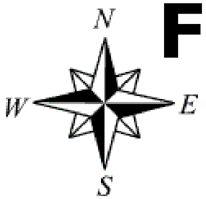
✓**Decline all verbal requests for negotiation.**

✓**Never sign a document to have a payment released or to ensure a prompt payment. Remember that your signature is not required to release payment; the government’s lien authorizes release of a payment.**

✓**Advise all TPC team members not to discuss payments with a pricing agent and to direct all calls of this nature to the denials manager or TPC manager.**



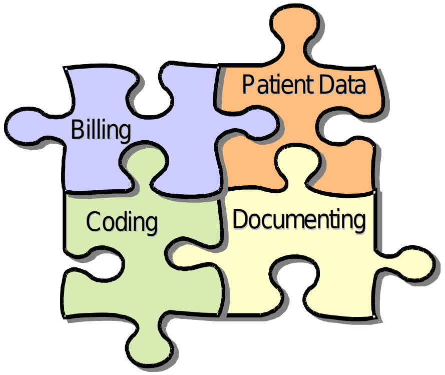
NAVIGATING REQUESTS FOR NEGOTIATION



More tips for managing negotiation requests

- ✓ **Prior negotiations signed by other staff, the previous contractor or even base legal do not obligate you to authorize or accept a reduction on future claims. Decline all offers regardless of what has occurred in the past.**
- ✓ **Once the offer is declined, advise the pricing agent that the claim must be immediately returned to the carrier for payment. Payment cannot be reduced due to the declined offer.**
- ✓ **Appeal all payments that appear to be out of network and refer all disputed claims after appeal, to your base legal department.**

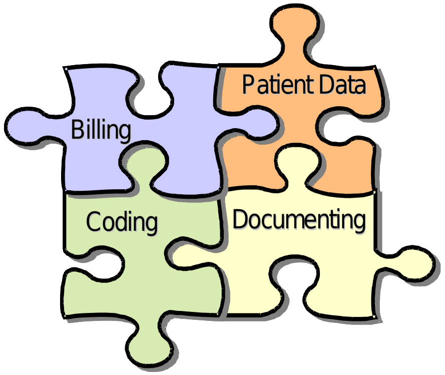
OUT OF NETWORK PAYMENTS BY PPO AND HMO CARRIERS



- Occurs whenever the carrier discounts, excludes charges or denies due to the absence of a PPO provider contract with the MTF.
- Reduction may have occurred after the carrier states the claim was paid at ‘100 percent of the allowable rate’.
- Could include no pre-certification or denial due to no HMO referral, which coincides with an already approved authorization.

CORE COMPETENCIES

OUT OF NETWORK PAYMENTS BY PPO AND HMO CARRIERS

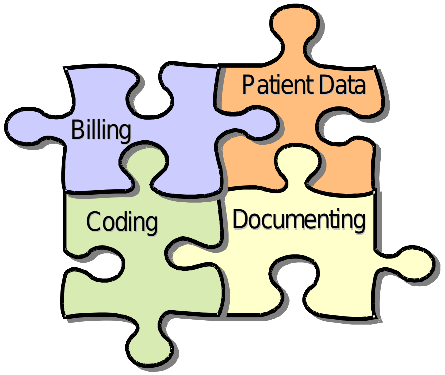


- **Carrier's continue out of net work payment claiming 10 USC 1095 does not apply to their plan or that they are excluded under other state or local or even other federal laws.**

- **Denial by the HMO as the patient 'opted out of network'. In other words, the patient chose to go to the MTF for treatment instead of their assigned HMO PCP.**

CORE COMPETENCIES

OUT OF NETWORK PAYMENTS BY PPO AND HMO CARRIERS

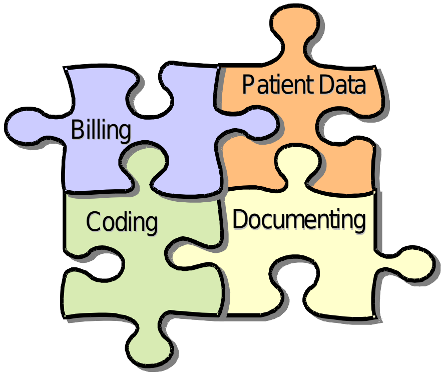


Tips for denials management of PPO’s and HMO’s

- ✓ **Always review the EOB to ensure payment is made according to benefits quoted.**
- ✓ **Discuss appeals options while on the phone with the carrier and always ask to have the claim escalated to a manager for reprocessing.**
- ✓ **Question the carrier’s response to a denial when an authorization is obtained, and the carrier reveals that a PCP referral is required to ‘activate’ the authorization. Challenge this process especially when this is not revealed at the time of verification of coverage and concurrent/utilization review.**

CORE COMPETENCIES

OUT OF NETWORK PAYMENTS BY PPO AND HMO CARRIERS

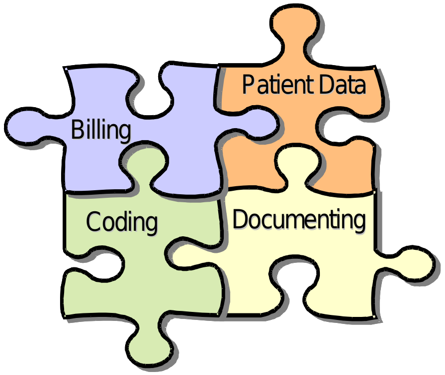

Patient Data
Billing
Coding
Documenting

Tips for denials management of PPO’s /HMO’s (con’t)

- ✓ **When submitting a written appeal make sure to include the section of 32 CFR 220.14 DEFINITIONS, whenever a carrier states that the plan is not required to operate under 10 U.S.C. 1095.**

CORE COMPETENCIES

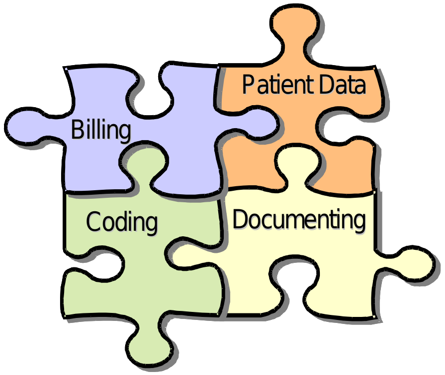
OUT OF NETWORK PAYMENTS BY PPO AND HMO CARRIERS



Definitions of Carrier Types

- ***Any Employee Retirement Income and Security Act (ERISA) plan.***
- ***Any Multiple Employer Trust (MET) plan.***
- ***Any Multiple Employer Welfare Arrangement (MEWA) plan***
- ***Any Health Maintenance Organization (HMO) plan, including POS (Point of Service) plan option.***
- ***Any Individual Practice Association (IPA) plan.***
- ***Any Exclusive Provider Organization (EPO) plan.***
- ***Any Physician Hospital Organization (PHO) plan.***
- ***Any Integrated Delivery System (IDS) plan.***
- ***Any Management Service Organization (MSO) plan.***
- ***Any group or individual medical services account***
- ***Any Preferred Provider Organization (PPO) plan or any PPO provision or option of a third party payer plan.***
- ***Any Medicare supplemental insurance plan.***
- ***Any auto liability insurance plan.***
- ***Any no fault insurance plan, i.e., PIP or medical payments benefit plan for personal injuries arising from the operation of a motor vehicle.***

OUT OF NETWORK PAYMENTS BY PPO AND HMO CARRIERS



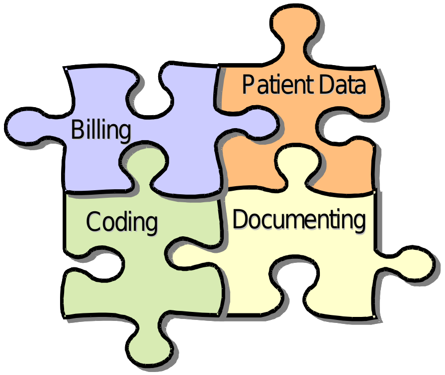
Tips for denials management of PPO’s/HMO’s (con’t)

- ✓ **Always submit appeals in writing and gather as many claims involved per carrier, as possible.**

- ✓ **Always involve your base legal department with issues involving a carrier continuing to pay out of network. Prepare your claims for placement to the legal department if your appeal is ignored by the carrier or the carrier’s legal representative.**

- ✓ **Demand that initial billing be submitted directly to the carrier, rather than a pricing agent as pricing is not appropriate for the MTF. Pricing agencies are compensated based on percentages of reduced payments on claims and MTF claims are not reduced, therefore, the pricing agency has no incentive to include statistics on claims which reflect no reduction. Consequently, pricing agencies do not acknowledge or forward MTF claims to carriers, which results in unnecessary rebilling.**

CORE COMPETENCIES



OUT OF NETWORK PAYMENTS BY PPO AND HMO CARRIERS

Tips for denials management of PPO’s/HMO’s (con’t)

- ✓ **Remember 32 CFR 220.2:**

  (a) Basic Rule. Pursuant to 10 U.S.C. 1095 (a)(1), a third party payer has an obligation to pay the United States the reasonable charges for healthcare services provided in or through any facility of the Uniformed Services to a covered beneficiary who is also a beneficiary under the third party payer’s plan. The obligation to pay is to the extent that the beneficiary would be eligible to receive reimbursement or indemnification from the third party payer if the beneficiary were to incur the costs on the beneficiary’s own behalf.

  (b) Application of cost shares.

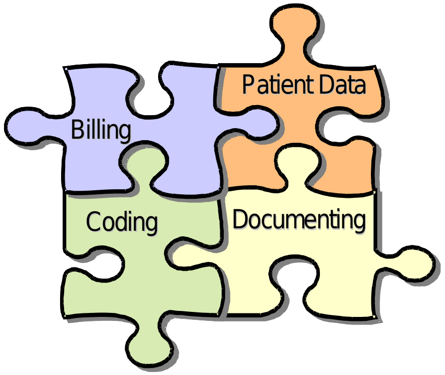
  (c) Claim from United States exclusive….Payment by a third party payer to the beneficiary does not satisfy 10 U.S.C. 1095

  (d) Assignment of benefits or other submission by beneficiary not necessary.

  (e)Preemption of conflicting State laws.

CORE COMPETENCIES

CONTRACTS VS PREVAILING RATES

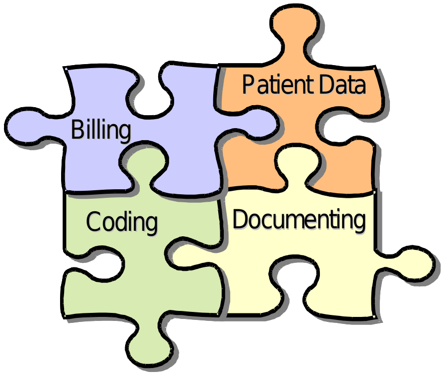


- **10 U.S.C.1095 strikes a careful balance. On the one hand, it disallows third party payer rules that would have the effect of excluding from coverage or limiting payment because the care was provided in a DoD facility. And a carrier cannot reduce or deny payment, because of a lack of a contract with a facility of the Uniformed Services.**

- **On the other hand, the statute does not require third party payers to make fundamental changes in their own rules in order to accommodate Government providers.**
    - ***32 CFR 220.8(l) has been referenced by some carriers in order to establish an 'alternative determination of reasonable charges' or a prevailing rate.***
    - ***If DoD rates are not representative of what a PPO perceives to be an optimal efficient practice as demonstrated by the rates of other providers in their network, DoD will accept the prevailing rate as payment in full.***

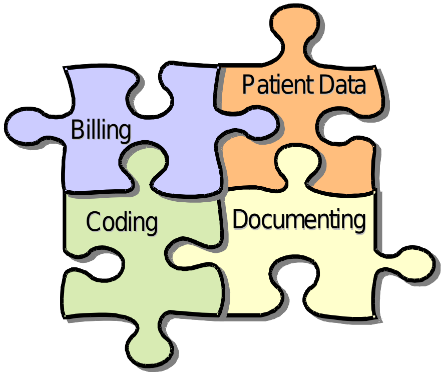
CORE COMPETENCIES

CONTRACTS VS PREVAILING RATES



  - *The PPO must furnish the required information as stated in 32 CFR 220.8(i)*
  - *This does not apply to cases covered by 32 CFR 220.11, which are auto and auto liability cases.*
- **Appropriate documentation and burden of proof is on the carrier, not the MTF.**
- **Review of the above does not obligate the carrier to assume that a contract has been negotiated with a DoD facility and vice-versa. The MTF must not assume that the rates have been accepted until the proper authority (UBO) has approved the terms.** ***(SEE 32 CFR 220.8-REASONABLE CHARGES)***

CONTRACTS VS PREVAILING RATES

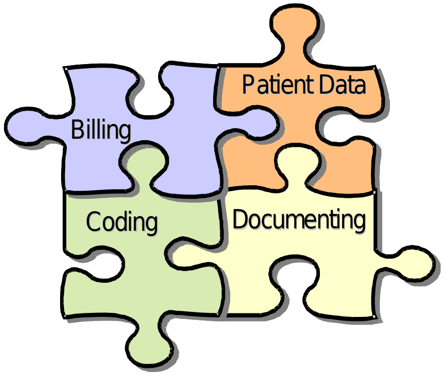


What does the UBO expect?

- The TPC program is to continue to appeal all out of network payments under authority of 10 U.S.C. 1095 and 32 CFR 220.
- Should 32 CFR 220.8(i) be referenced by a carrier, that carrier is required to show proof that the plan's PPO prevailing rates of payment paid to preferred providers in the same geographic area is lower than DoD rates, and is required to provide all documents to the MTF in writing.
- The MTF must pass along such requests and documentation for review and determination of payment to the UBO.

CORE COMPETENCIES

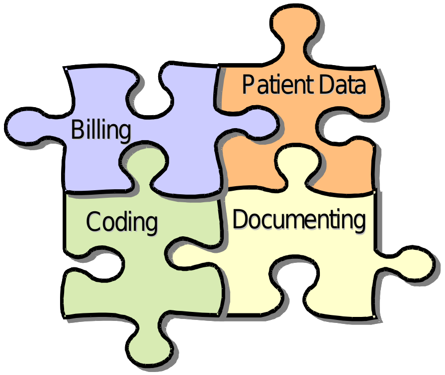
CONTRACTS VS PREVAILING RATES



Tips for denials management when a discount or prevailing rate is requested by a carrier

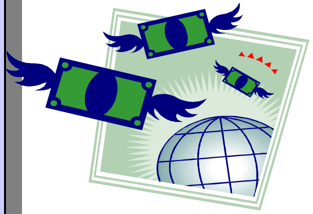
- ✓ Do not agree to anything, verbally or in writing. If you receive a call, it is recommended that you forward the call to your base legal dept.
- ✓ Do not submit the facility’s pricing or ASA rates from the federal register website as an agreement to a proposal or allow the carrier to believe it has been given the ‘green light’ to begin reducing payments
- ✓ Do involve your base legal department and UBO manager for guidance.

CONTRACTS VS PREVAILING RATES

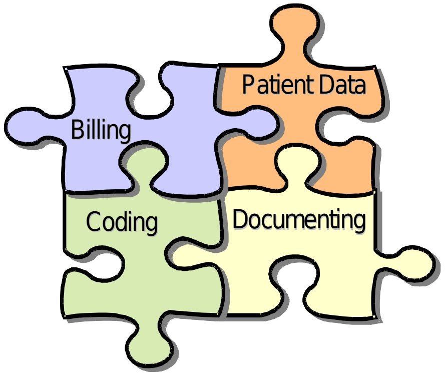


Tips for denials management when a discount or prevailing rate is requested by a carrier (con’t)

- ✓ Strongly emphasize with the carrier that delivery or review of their prevailing rates does not constitute permission to reimburse the facility at the rates proposed; the UBO is the only U.S. Government authority to notify you of this procedure.
- ✓ Review subsequent EOBs, paying attention to any questionable reduction, after the carrier has requested DoD review and approval of prevailing rates is pending.



RECOUPMENTS VS. REFUND REQUESTS

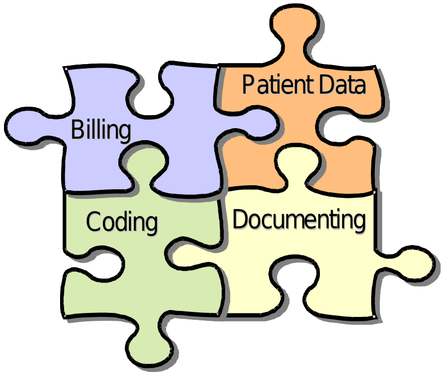


Occurs when a carrier reduces a payment on the grounds that a refund is due.

- **32 CFR 220.7 (d) disallows plans from offsetting payment, without the consent of an authorized government official, to a facility of the Uniformed Services because the payer considers itself due a refund.**
- **Since it is standard practice to recoup from contracted providers instead of requesting, most carriers will plead their right to recoup. But an authorized representative of a facility of the Uniformed Services is the only entity who may compromise, settle or waive a claim.**

CORE COMPETENCIES

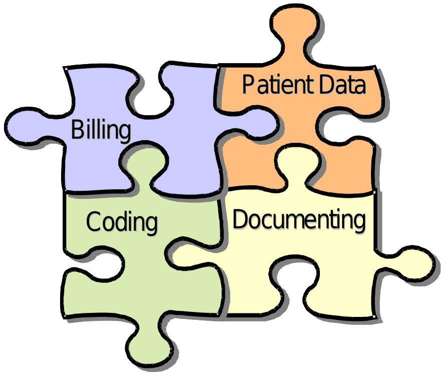
RECOUPMENTS VS. REFUND REQUESTS



Tips for Denials Management of Recoupments

- ✓ **Review EOBs carefully to determine if a payment has been reduced by a recoupment or offset.**
- ✓ **Request carrier to reprocess your claim immediately and demand that a refund request be made in writing.**
- ✓ **Submit the CFR in writing whenever necessary.**
- ✓ **Continue to follow up to ensure the claim has been reprocessed and the recouped payment is received.**
- ✓ **Investigate every refund request before complying as you may receive requests that are either duplicates or invalid.**

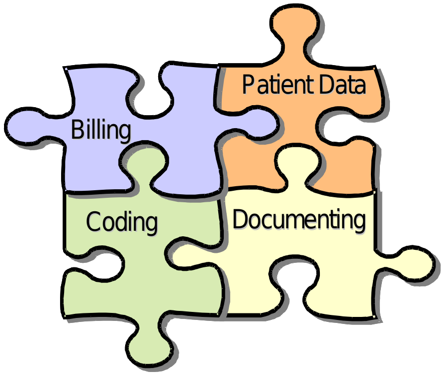
Sunset Provision of 32 CFR 220.12



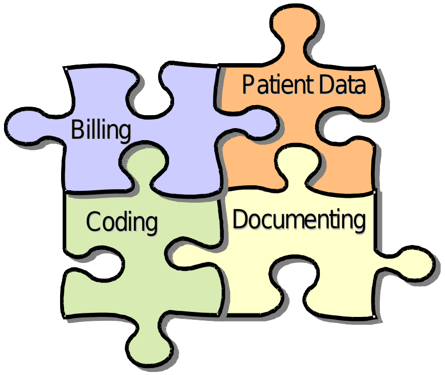
- Special rules for PPO plans are effective 17 Mar 2000 with Sunset Provision effective 01 Oct 2004.
- Sunset provision effective for all FEHBP plans paying facilities of the Uniformed Services and PPO plans of Uniformed Services beneficiaries.
- Special Rules applicable to the sunset provision include
  - Excluding coverage or limiting payment.
  - PPO agreement not required.
  - Accommodation of PPO’s fundamental price and utilization review standards.
  - Requirements that a PPO accepts all Uniform Services beneficiaries. A facility of the Uniformed Services may provide health care services only to persons with eligibility (Uniformed Services Beneficiaries) pursuant to 10 U.S.C. Chapter 55.

CORE COMPETENCIES

Sunset Provision of 32 CFR 220.12



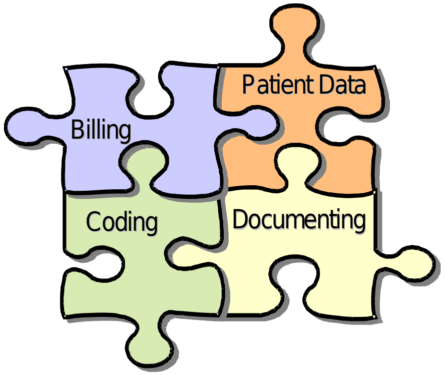
- Special Rules (con’t)
  - Impermissible requirement of PPO provider (physician) to meet credentialing, licensing, certification or other requirements to prove quality of care.
  - Impermissible requirement that a PPO restricts patient referral to only providers within the PPO.
  - Any other PPO requirement that would purport to require a facility of the Uniformed Services, in order to effectuate the legislative purpose of 10 U.S.C. 1095, to act in a manner inconsistent with the basic nature of facilities of the Uniformed Services.



Sunset Provision of 32 CFR 220.12

- While the sunset provision applies to all FEHBP plans, non FEHBP plans may follow suit with the Sunset Provision.
- According to the UBO 10 U.S.C. 1095 remains in force, as well as the remaining parts of 32 CFR 220. All claims must be paid at in network rates, PPO contracts will not be negotiated, and claims from facilities of the Uniformed Services cannot be paid less than other in network providers or excluded from payment.

CORE COMPETENCIES

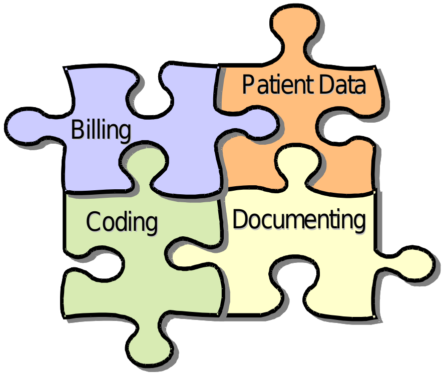


Sunset Provision of 32 CFR 220.12

Tips for denials management of plans affected by the Sunset Provision

- ✓ **It is business as usual; appeal all out of network claims with the backup of 10 U.S.C. 1095 and remaining portions of 32 CFR 220.**
- ✓ **Track FEHBP and non FEHBP PPO claims that are processed with reductions.**
- ✓ **Be prepared for resistance especially from the FEHBP plans and particularly Mail Handlers.**

Sunset Provision of 32 CFR 220.12

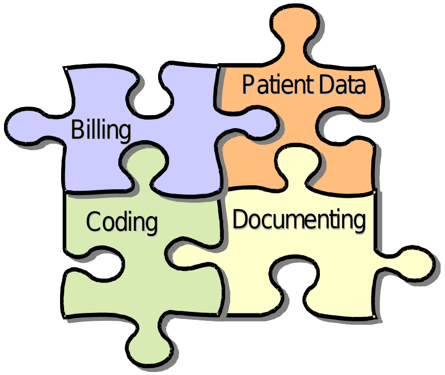


Tips for denials management of plans affected by the Sunset Provision (con’t)

- ✓ **Be aware of any claims that are processed both with a discount (that implies a contractual relationship) and with the balance paid at the out of network rate. The carrier cannot process your claims under both premises; the claim must be paid in network, and without discounts of any sort.**
- ✓ **Remember your base legal representative and the UBO manager, when requiring further guidance.**

CORE COMPETENCIES

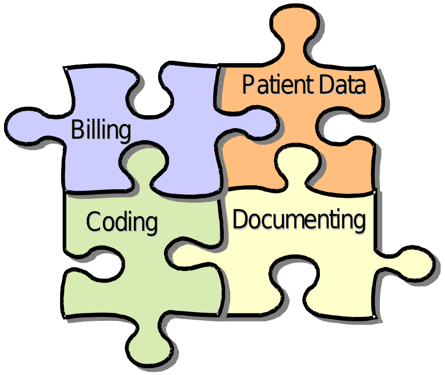
WHEN TO USE THE BASE LEGAL DEPARTMENT



Base legal should be brought into the denials management process when

- **An excessive amount of claims deny by the same carrier for the same reason.**
- **You have already appealed an out of network payment, and your appeal has been denied.**
- **A carrier continues to pay out of network or accuses the facility of overcharging and additional information must be provided before claims will be reprocessed.**
- **In the case of civilian trauma or accident, your base legal department must negotiate a settlement with the carrier or the patient's legal representative.**

WHEN TO USE THE BASE LEGAL DEPARTMENT

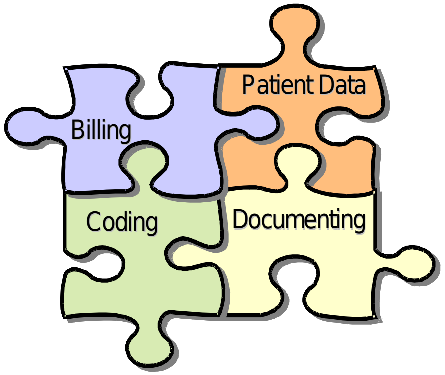


Tips when communicating with the base legal department

- ✓ Remember to ‘use’ your base legal department to assist you with denials management and do not ‘abuse’ this department by forwarding claims not completed or that require an initial appeal or other phone calls.
- ✓ Make sure that you gather all documents, denial letters, appeal letters and medical records when forwarding claims to base legal.
- ✓ Maintain open communication and dialogue with the base legal representative; that department is available to assist you.

CORE COMPETENCIES

WHEN TO USE THE BASE LEGAL DEPARTMENT

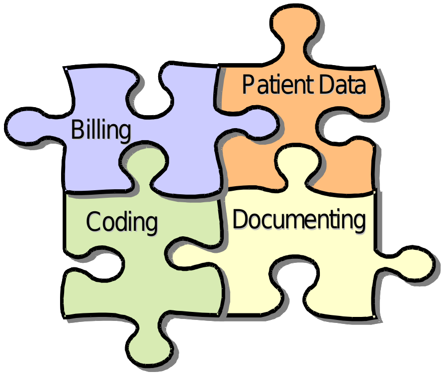


Tips when communicating with the base legal department (con’t)

- ✓ **Consult with the base legal representative and ask questions if a carrier presents information that is unknown to you.**
- ✓ **The base legal department will advise regarding any other requirements or limitations.**

C O R E C O M P E T E N C I E S

Summary

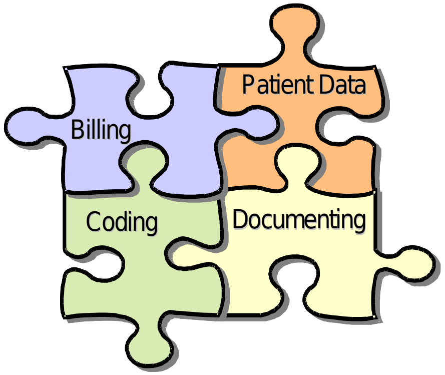


- **Negotiations are never appropriate in the MTF setting.**
- **All out of network reductions can be appealed using 10 USC 1095 and 32 CFR 220.**
- **Prevailing rates are subject to the scrutiny of the UBO.**
- **Recoupments can be reversed and claims reprocessed. Refund requests are not binding.**
- **10 USC 1095 and 32 CFR 220 remain intact.**
- **Make base legal an integral part of denials management.**

CORE COMPETENCIES

UBOquestions@benefitrecovery.co

CORE COMPETENCIES

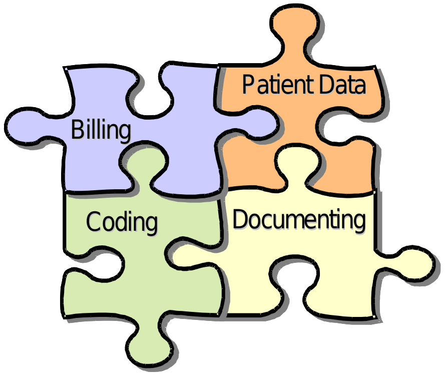

Patient Data
Billing
Coding
Documenting

Patient Category Codes (PATCATs) – What You Don’t Know Can Hurt You!

Mr. Russ Coleman, MHA, CHE
17 May 2005
Track 4, UBO Advanced

CORE COMPETENCIES

Objectives


Patient Data
Billing
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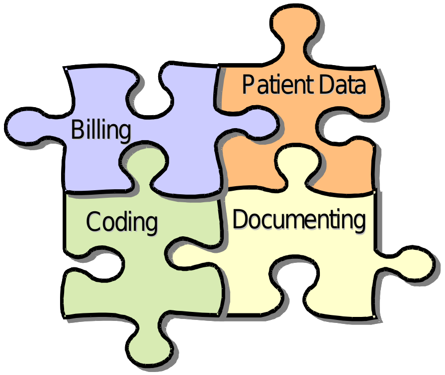
Documenting

- Know the purpose of Patient Categories (PATCATs)
- Understand why PATCATs are important Know how PATCAT codes are structured/assigned
- Be able to identify common…and not-so-common…PATCATs
- Know where to obtain get help with PATCATs
- Understand coming changes in PATCATs

CORE COMPETENCIES

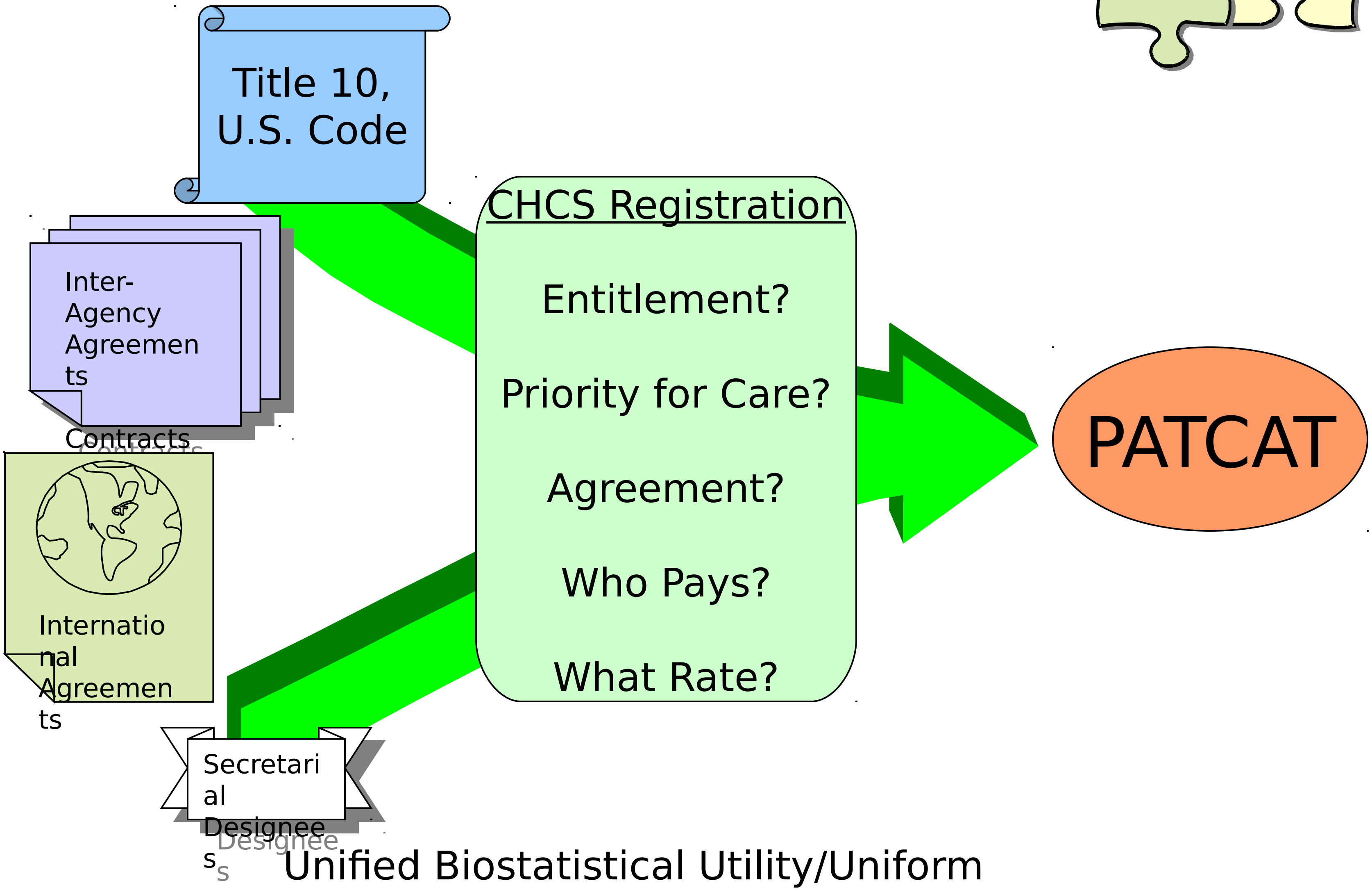
Background: Purpose of PATCATs



- PATCAT Codes are closely linked to entitlements under the Uniformed Services Health Benefits Program (USHBP)
- They allow identification and grouping of patients by ‘types’ of interest
  - Sponsor Service
  - Beneficiary Category
  - Special Interest patient groups
- PATCATs are directly linked to UBO Billing
  - Rate to charge and method of billing

CORE COMPETENCIES

Background: The Making of PATCATs



Title 10, U.S. Code

Inter-Agency Agreements

Contracts

International Agreements

Secretarial Designees

CHCS Registration

Entitlement?

Priority for Care?

Agreement?

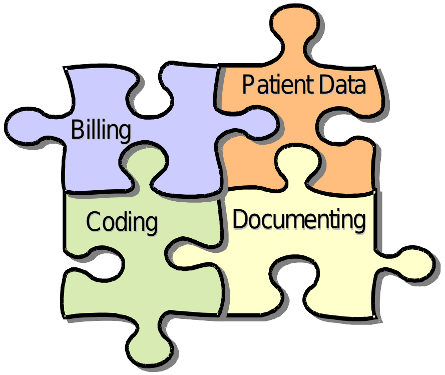
Who Pays?

What Rate?

PATCAT

CORE COMPETENCIES

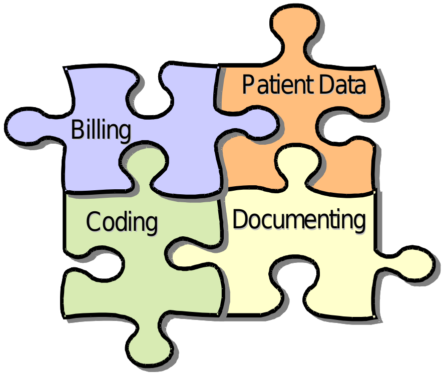
Operationally, Who Has An Interest PATCATs?


Billing
Patient Data
Coding
Documenting

- Personnel Community (DEERS)
- Patient Administration
- UBO/Medical Services Account
- Management at all levels
- Data Analysts

CORE COMPETENCIES

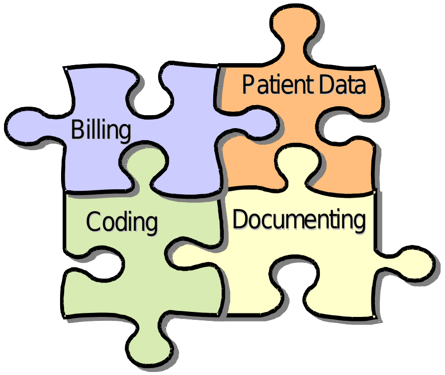
What Is Affected By PATCATs?



- Many CHCS functions, and downstream systems rely on PATCATs
  - Patient classification by Beneficiary Category
  - Admission & Disposition Reports
  - Patient Record Extracts (SADR, SIDR, HL7)
  - Workload reports (MEPRS, WWR)
- Bad PATCATs = Poor Data Quality = Rework, Lost Money, Bad Decisions

CORE COMPETENCIES

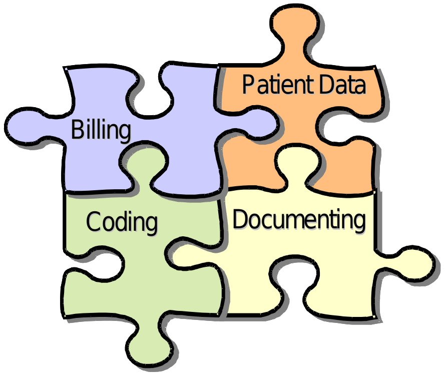
How Are You Hurt in UBO By “Bad” PATCAT Data?


Patient Data
Billing
Coding
Documenting

- For UBO, bad PATCATs can cause many problems and much rework:
  - Not billing when you should
  - Billing when you should not
  - Billing at the wrong rate
  - Billing to the wrong source
  - Billing using the wrong forms

CORE COMPETENCIES

PATCAT Assignment Data and Process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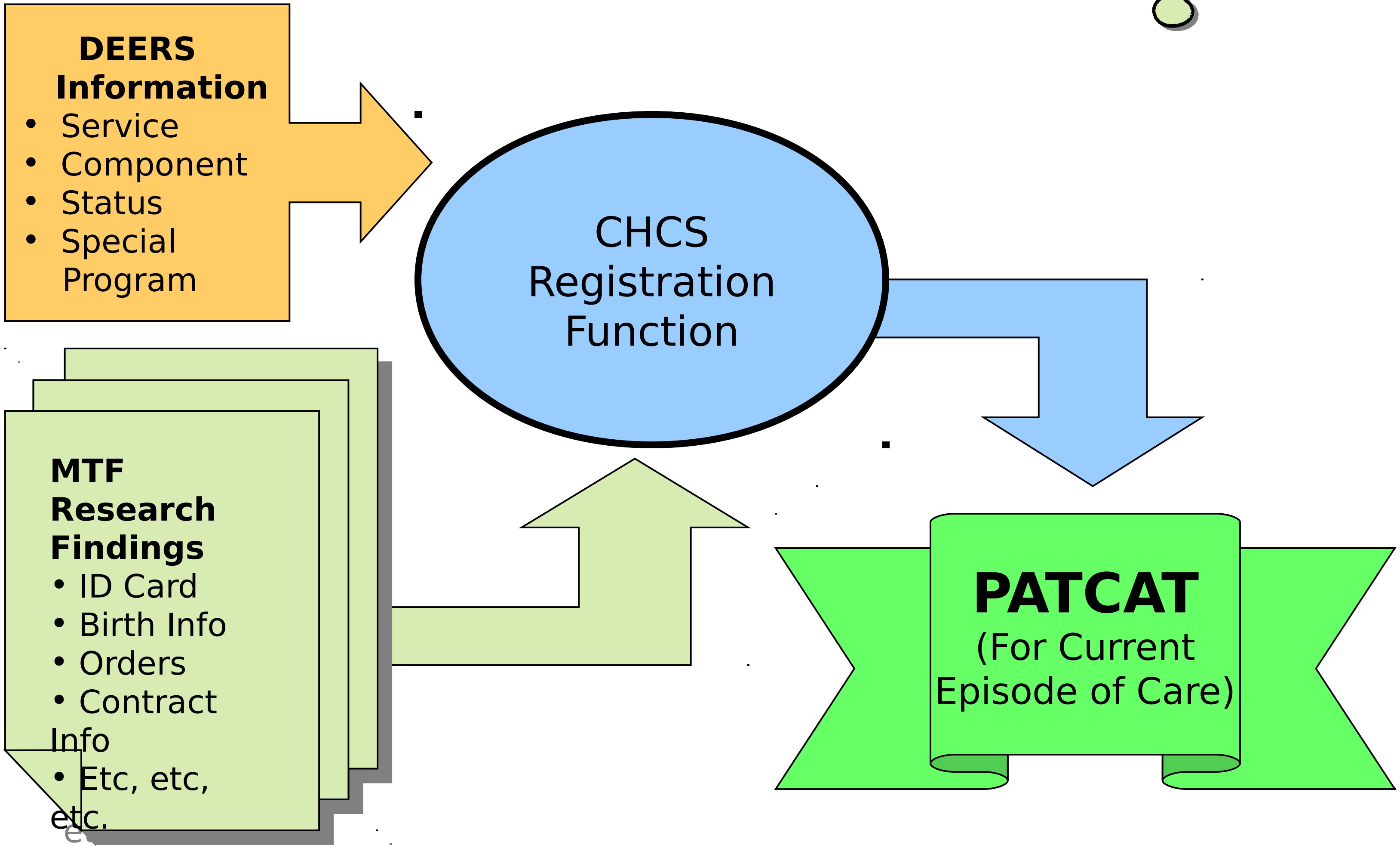


DEERS Information
- Service
- Component
- Status
- Special Program

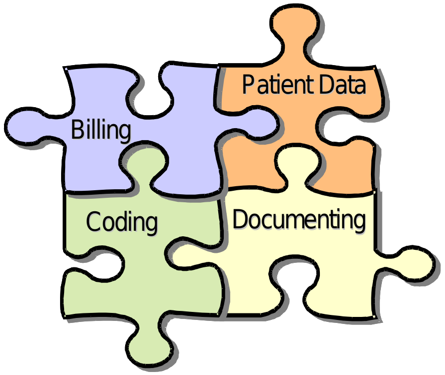
CHCS Registration Function

MTF Research Findings
- ID Card
- Birth Info
- Orders
- Contract Info
- Etc, etc, etc.

PATCAT
(For Current Episode of Care)

CORE COMPETENCIES

Patient Category Assignments Can Change Over Time


Patient Data
Billing
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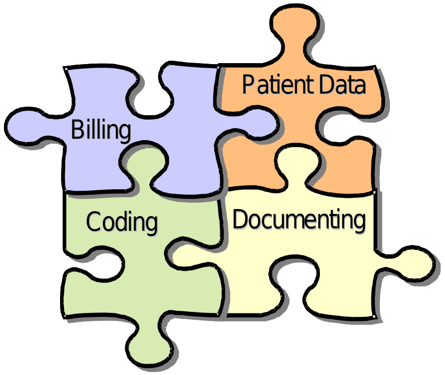
Documenting

- Active Duty → Retired
  - Change in billing for the Sponsor
- Inactive Reserve ↔ Active Duty
  - Change in billing for family members
- Active Duty → TAMP
  - Change in billing for Sponsor
- TAMP → TRICARE Reserve Select
  - Change in billing for Sponsor

Getting Additional PATCAT Information in CHCS



PATCAT Description Field

The description field in this Patient Category Billing Table is limited to 24 characters/spaces, so in some cases the description field is cut short.

Example is A12:

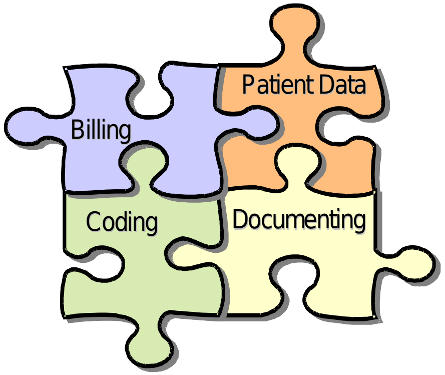
```
A12  USA AD RES-30 DAYS OR LE   FRR   NC     FOR    NC
```

To find out what the complete description field is, you can use the MSA function:

FIM/Inquire to File Entries.

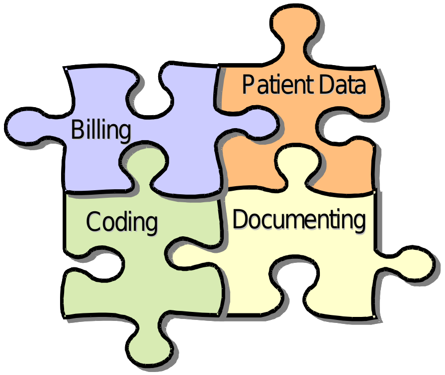
NOTE: If you do not have access to this option it is because a security key locks the function: DIOUT. Ask your CHCS site Help Desk or system staff if you can have this security key assigned to you.

Using the CHCS "FIM Inquire" Option Get More PATCAT Information



Menu Path: MSA->FIM->Patient Category:
Select Core Application Drivers Menu Option**: MSA**
Select MSA System Menu Option: **FIM Inquire to File Entries**
Output from what file: **PATIENT CATEGORY {enter Patient Category and press the enter key}**
Select PATIENT CATEGORY NAME: **A12 {enter the Code you want and press the enter key}**
1 A12 USA AD RES ENLISTED A12
2 A12 USA AD RES OFFICER A12
3 A12 USA AD RES-30 DAYS OR LESS, NOT LOD A12
Choose 1-3: **3 {choose the correct category and press the enter key, you will notice that the complete description is shown here also}**
Another one: **{make another Category selection, or just press the enter key}**
Standard CAPTIONED output? YES// **{press the enter key}**

Our selection



Result of Inquiry for PATCAT Code A12

The result of our query:

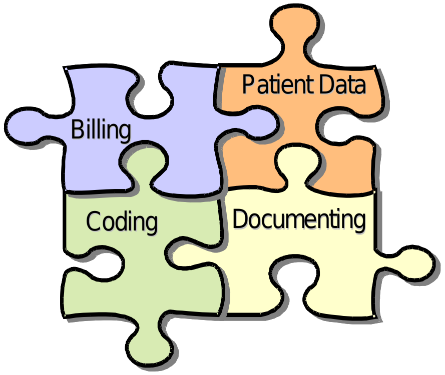
PATCAT Code A12 B

NAME : **USA AD RES-30 DAYS OR LESS, NOT LOD** **CODE**: A12
A&D LIST CATEGORY: ACTIVE DUTY **SPONSOR**: YES **FAMILY MEMBER**: NO
CIVILIAN EMERGENCY: NO **DECEASED SPON**: NO
PROHIBIT DEERS ELIG TRANS: NO **PAT CAT SUMMARY**: ACTIVE DUTY
THIRD LEVEL DESCRIPTION: USA AD RES **SHORT DESCRIPTION**: USA AD RES <30 D
SUB CATEGORY: B
IPNT INDIVIDUAL SALES CD: **FRR** **IPNT AGENCY RATE**: **NC**
OPNT INDIVIDUAL SALES CD: **FOR** **OPNT AGENCY RATE**: **NC**
STATUS OF PATIENT: ACTIVE DUTY
ACTIVATION/INACTIVATION DATE: 14 Dec 1995 **ACTIVE/INACTIVE STATUS**: ACTIVE

Charge/Sales Codes

NOTE: These columns are not in the PATCAT Table spreadsheet file

Sample CHCS Display of PATCAT Code Information



MSA->MSR->PCT/Patient Category Billing Table
Sample list of some codes

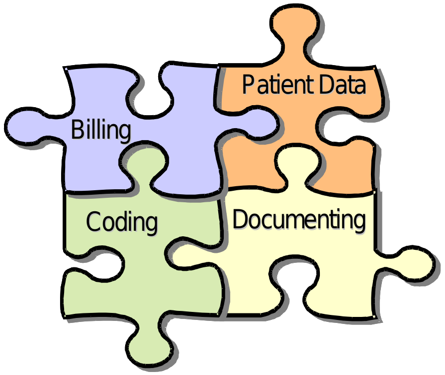
MALCOLM GROW MED CEN ANDREWS AFB MD (AMC) 11 Apr 2005 0907 Page 1
*** * * PATIENT CATEGORY BILLING TABLE * * ***

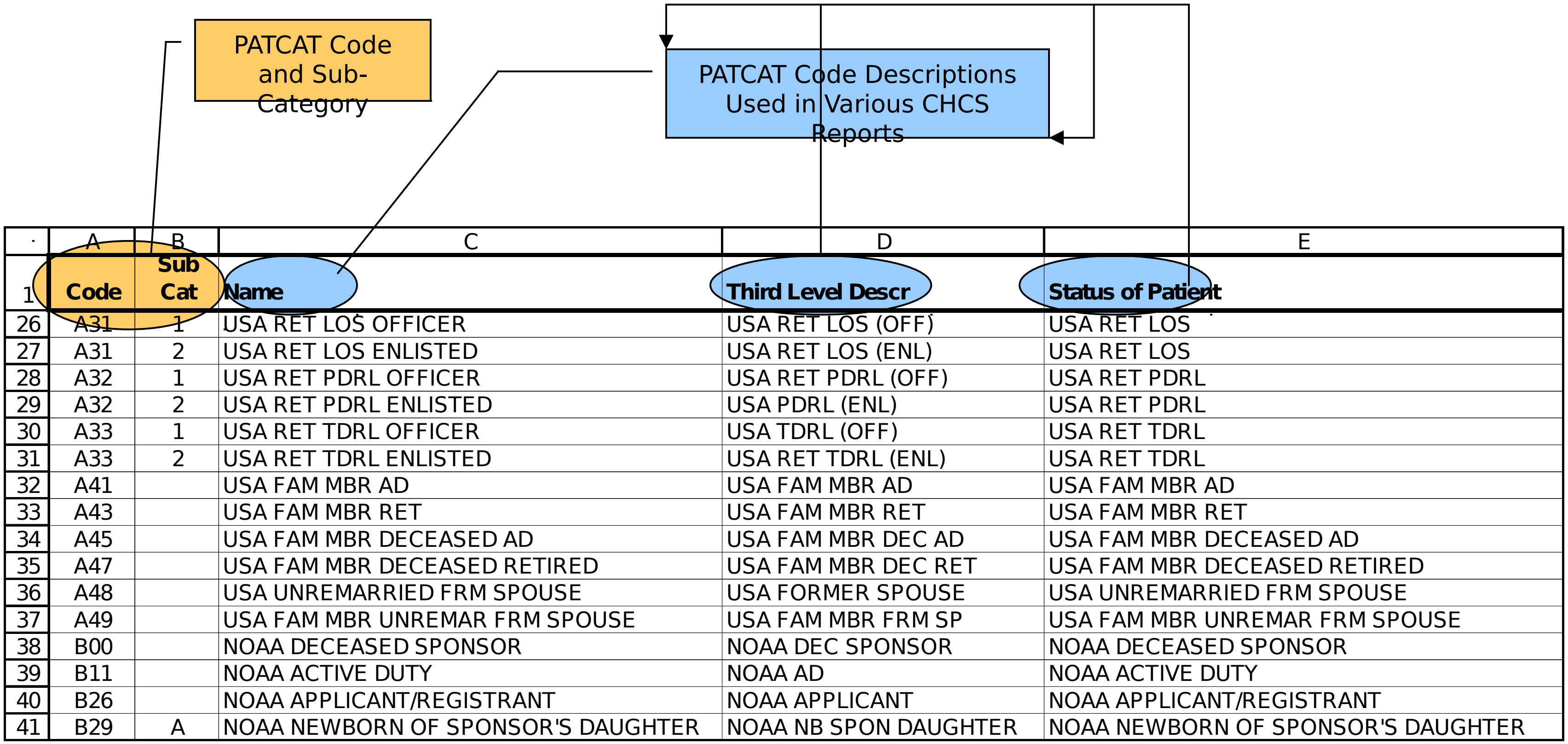
Code	Description	Inpatient Ind	Inpatient Agy	Outpatient Ind	Outpatient Agy	Pay Mode	~~Enl Allow 1080 DD139~~
A11	USA ACTIVE DUTY ENLISTED	SR	NC	NC	NC	ENL1080/DD139	
A11	USA ACTIVE DUTY OFFICER	SR	NC	NC	NC	DD139	
A12	USA AD RES ENLISTED	SR	NC	NC	NC	ENL1080/DD139	
A12	USA AD RES OFFICER	SR	NC	NC	NC	DD139	
A12	USA AD RES-30 DAYS OR LE	FRR	NC	FOR	NC		
A13	USA AD RECRUIT	NC	SR	NC	NC	DD7/DD7A	
A14	USMA CADET	NC	SR	NC	NC	DD7/DD7A	
A15	USA NG ENLISTED	SR	NC	NC	NC	ENL1080/DD139	
A15	USA NG OFFICER	SR	NC	NC	NC	DD139	
A15	USA NG-30 DAYS OR LESS,	FRR	NC	FOR	NC		
A21	USA ROTC	SR	NC	NC	NC	DD139	
B11	NOAA ACTIVE DUTY	NC	IAR	NC	IOR	DD7/DD7A	
C11	USCG ACTIVE DUTY	NC	IAR	NC	IOR	DD7/DD7A	

NOTE: SR is no longer billed for selected PATCATs

CORE COMPETENCIES

What’s in the PATCAT Table? – Part 1





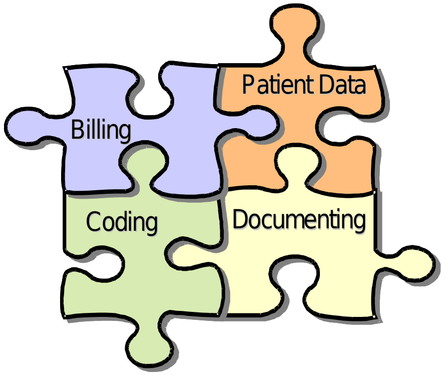
PATCAT Code and Sub-Category

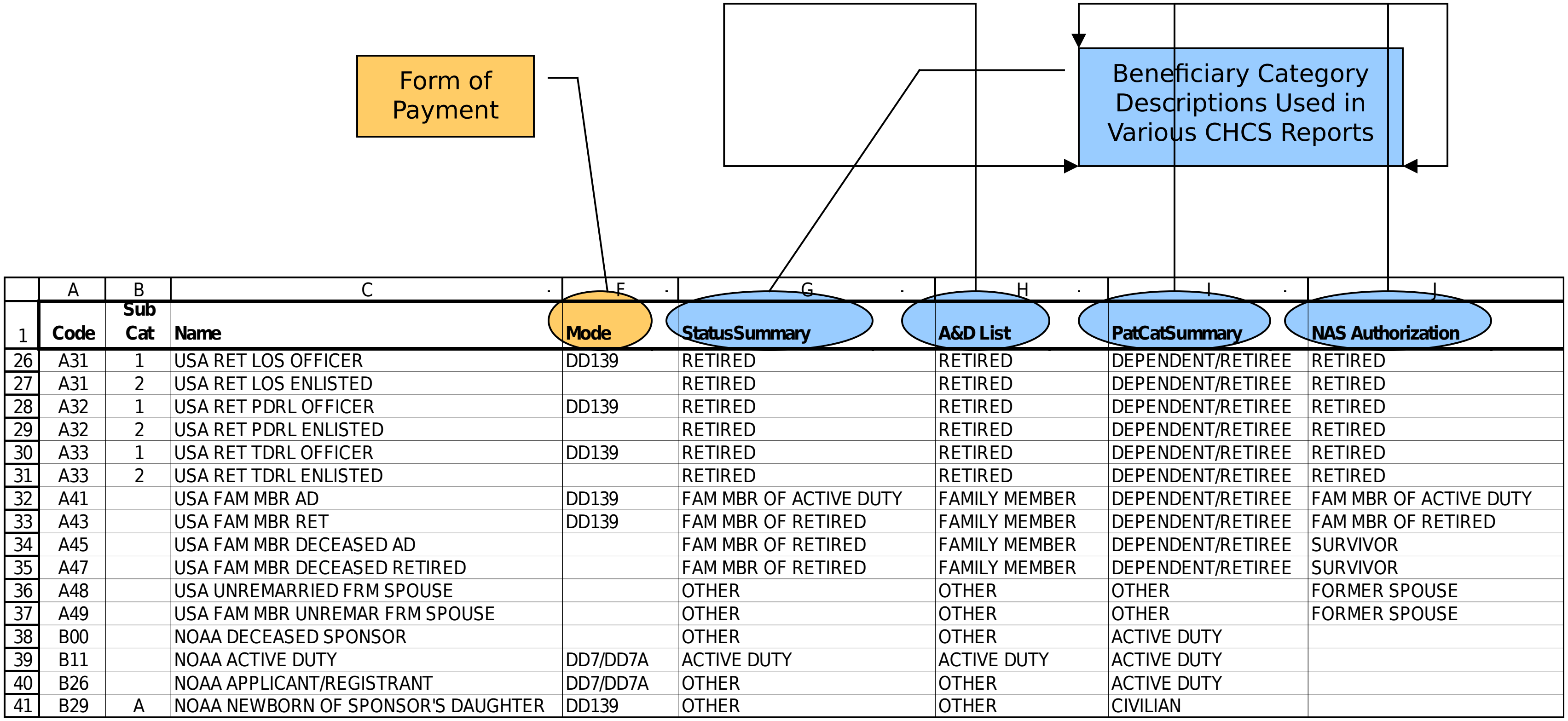
PATCAT Code Descriptions Used in Various CHCS Reports

	A	B	C	D	E
1	**Code**	**Sub Cat**	**Name**	**Third Level Descr**	**Status of Patient**
26	A31	1	USA RET LOS OFFICER	USA RET LOS (OFF)	USA RET LOS
27	A31	2	USA RET LOS ENLISTED	USA RET LOS (ENL)	USA RET LOS
28	A32	1	USA RET PDRL OFFICER	USA RET PDRL (OFF)	USA RET PDRL
29	A32	2	USA RET PDRL ENLISTED	USA PDRL (ENL)	USA RET PDRL
30	A33	1	USA RET TDRL OFFICER	USA TDRL (OFF)	USA RET TDRL
31	A33	2	USA RET TDRL ENLISTED	USA RET TDRL (ENL)	USA RET TDRL
32	A41		USA FAM MBR AD	USA FAM MBR AD	USA FAM MBR AD
33	A43		USA FAM MBR RET	USA FAM MBR RET	USA FAM MBR RET
34	A45		USA FAM MBR DECEASED AD	USA FAM MBR DEC AD	USA FAM MBR DECEASED AD
35	A47		USA FAM MBR DECEASED RETIRED	USA FAM MBR DEC RET	USA FAM MBR DECEASED RETIRED
36	A48		USA UNREMARRIED FRM SPOUSE	USA FORMER SPOUSE	USA UNREMARRIED FRM SPOUSE
37	A49		USA FAM MBR UNREMAR FRM SPOUSE	USA FAM MBR FRM SP	USA FAM MBR UNREMAR FRM SPOUSE
38	B00		NOAA DECEASED SPONSOR	NOAA DEC SPONSOR	NOAA DECEASED SPONSOR
39	B11		NOAA ACTIVE DUTY	NOAA AD	NOAA ACTIVE DUTY
40	B26		NOAA APPLICANT/REGISTRANT	NOAA APPLICANT	NOAA APPLICANT/REGISTRANT
41	B29	A	NOAA NEWBORN OF SPONSOR'S DAUGHTER	NOAA NB SPON DAUGHTER	NOAA NEWBORN OF SPONSOR'S DAUGHTER

CORE COMPETENCIES

What’s in the PATCAT Table? – Part 2





Form of Payment

Beneficiary Category Descriptions Used in Various CHCS Reports

	A	B	C	F	G	H	I	J
1	**Code**	**Sub Cat**	**Name**	**Mode**	**StatusSummary**	**A&D List**	**PatCatSummary**	**NAS Authorization**
26	A31	1	USA RET LOS OFFICER	DD139	RETIRED	RETIRED	DEPENDENT/RETIREE	RETIRED
27	A31	2	USA RET LOS ENLISTED		RETIRED	RETIRED	DEPENDENT/RETIREE	RETIRED
28	A32	1	USA RET PDRL OFFICER	DD139	RETIRED	RETIRED	DEPENDENT/RETIREE	RETIRED
29	A32	2	USA RET PDRL ENLISTED		RETIRED	RETIRED	DEPENDENT/RETIREE	RETIRED
30	A33	1	USA RET TDRL OFFICER	DD139	RETIRED	RETIRED	DEPENDENT/RETIREE	RETIRED
31	A33	2	USA RET TDRL ENLISTED		RETIRED	RETIRED	DEPENDENT/RETIREE	RETIRED
32	A41		USA FAM MBR AD	DD139	FAM MBR OF ACTIVE DUTY	FAMILY MEMBER	DEPENDENT/RETIREE	FAM MBR OF ACTIVE DUTY
33	A43		USA FAM MBR RET	DD139	FAM MBR OF RETIRED	FAMILY MEMBER	DEPENDENT/RETIREE	FAM MBR OF RETIRED
34	A45		USA FAM MBR DECEASED AD		FAM MBR OF RETIRED	FAMILY MEMBER	DEPENDENT/RETIREE	SURVIVOR
35	A47		USA FAM MBR DECEASED RETIRED		FAM MBR OF RETIRED	FAMILY MEMBER	DEPENDENT/RETIREE	SURVIVOR
36	A48		USA UNREMARRIED FRM SPOUSE		OTHER	OTHER	OTHER	FORMER SPOUSE
37	A49		USA FAM MBR UNREMAR FRM SPOUSE		OTHER	OTHER	OTHER	FORMER SPOUSE
38	B00		NOAA DECEASED SPONSOR		OTHER	OTHER	ACTIVE DUTY	
39	B11		NOAA ACTIVE DUTY	DD7/DD7A	ACTIVE DUTY	ACTIVE DUTY	ACTIVE DUTY	
40	B26		NOAA APPLICANT/REGISTRANT	DD7/DD7A	OTHER	OTHER	ACTIVE DUTY	
41	B29	A	NOAA NEWBORN OF SPONSOR'S DAUGHTER	DD139	OTHER	OTHER	CIVILIAN	

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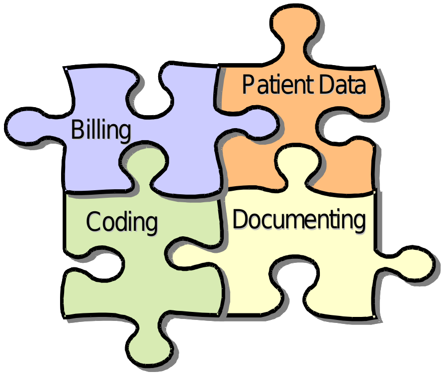
What’s in the PATCAT Table? – Part 3



Inpatient Rate Info: Individual or Agency and Type of Rate

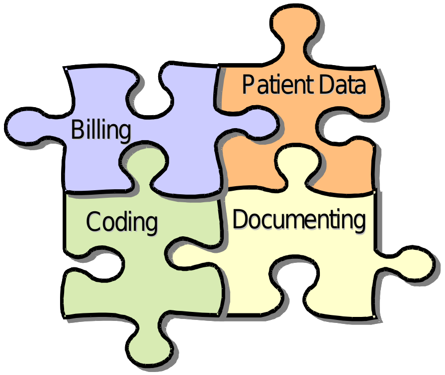
Outpatient Rate Info: Individual or Agency and Type of Rate

	A	B	C	K	L	M	N
1	**Code**	**Sub Cat**	**Name**	**Ipnt Indiv**	**Ipnt Agency**	**Opnt Indiv**	**Opnt Agency**
26	A31	1	USA RET LOS OFFICER	SR	NC	NC	NC
27	A31	2	USA RET LOS ENLISTED	NC	NC	NC	NC
28	A32	1	USA RET PDRL OFFICER	SR	NC	NC	NC
29	A32	2	USA RET PDRL ENLISTED	NC	NC	NC	NC
30	A33	1	USA RET TDRL OFFICER	SR	NC	NC	NC
31	A33	2	USA RET TDRL ENLISTED	NC	NC	NC	NC
32	A41		USA FAM MBR AD	FMR	NC	NC	NC
33	A43		USA FAM MBR RET	FMR	NC	NC	NC
34	A45		USA FAM MBR DECEASED AD	FMR	NC	NC	NC
35	A47		USA FAM MBR DECEASED RETIRED	FMR	NC	NC	NC
36	A48		USA UNREMARRIED FRM SPOUSE	FMR	NC	NC	NC
37	A49		USA FAM MBR UNREMAR FRM SPOUSE	FMR	NC	NC	NC
38	B00		NOAA DECEASED SPONSOR	NC	NC	NC	NC
39	B11		NOAA ACTIVE DUTY	NC	IAR	NC	IOR
40	B26		NOAA APPLICANT/REGISTRANT	NC	IAR	NC	IOR
41	B29	A	NOAA NEWBORN OF SPONSOR'S DAUGHTER	FMR	NC	NC	NC

NOTE: SR no longer charged for AD Officers

CORE COMPETENCIES

What’s in the PATCAT Table? – Part 4

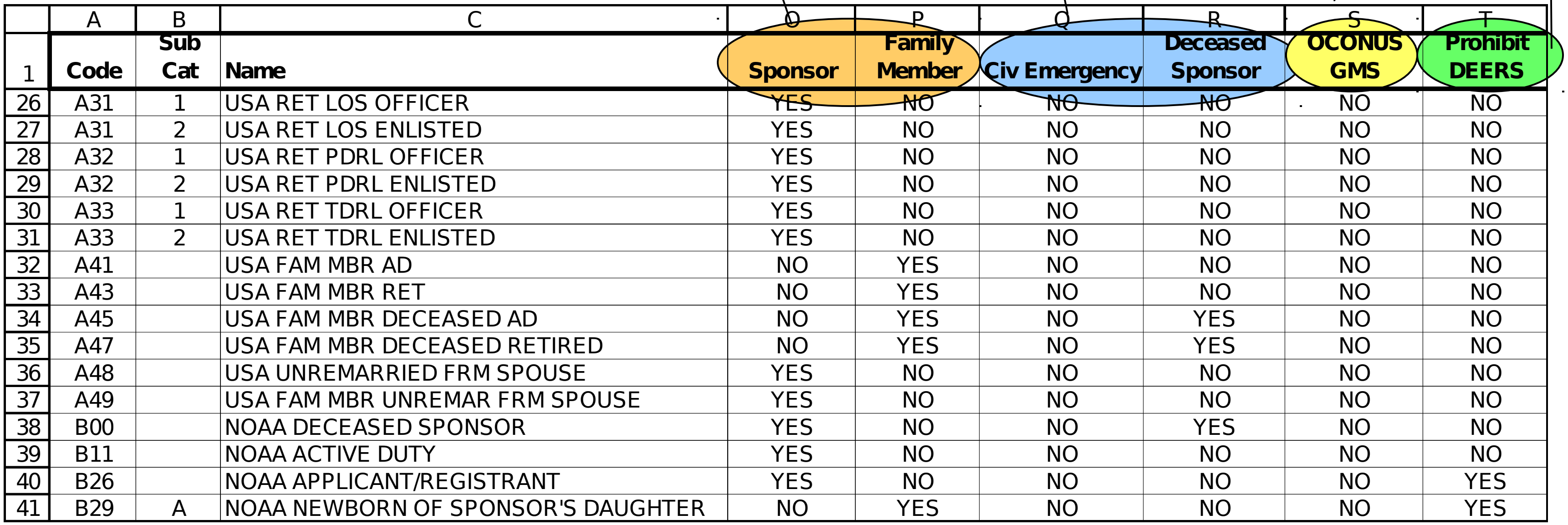


Categorizes patients as Sponsor or Family Member

Special Interest Reporting Categories

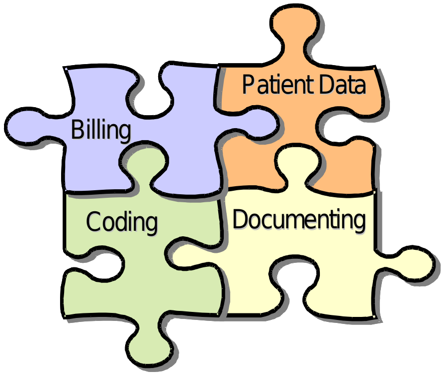
OCONUS Group Meal Sales

Can you skip a DEERS check?

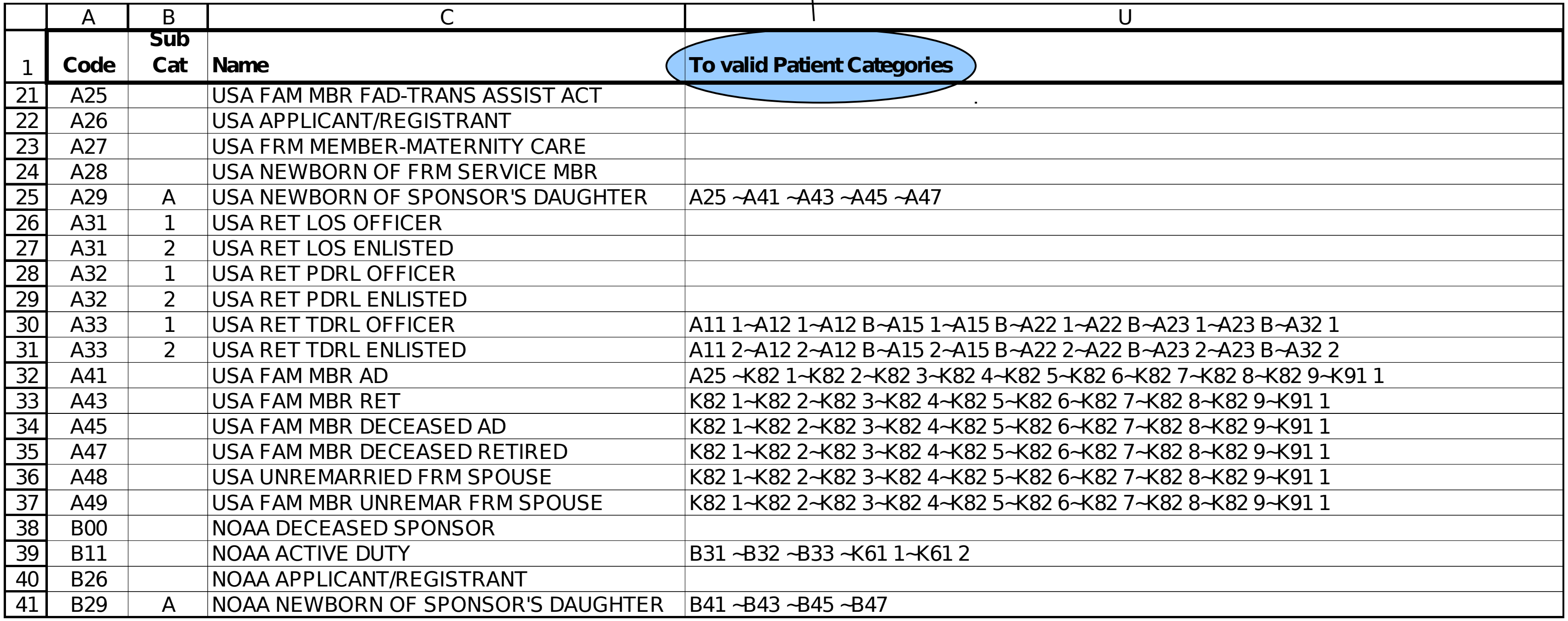


	A	B	C	O	P	Q	R	S	T
1	Code	Sub Cat	Name	Sponsor	Family Member	Civ Emergency	Deceased Sponsor	OCONUS GMS	Prohibit DEERS
26	A31	1	USA RET LOS OFFICER	YES	NO	NO	NO	NO	NO
27	A31	2	USA RET LOS ENLISTED	YES	NO	NO	NO	NO	NO
28	A32	1	USA RET PDRL OFFICER	YES	NO	NO	NO	NO	NO
29	A32	2	USA RET PDRL ENLISTED	YES	NO	NO	NO	NO	NO
30	A33	1	USA RET TDRL OFFICER	YES	NO	NO	NO	NO	NO
31	A33	2	USA RET TDRL ENLISTED	YES	NO	NO	NO	NO	NO
32	A41		USA FAM MBR AD	NO	YES	NO	NO	NO	NO
33	A43		USA FAM MBR RET	NO	YES	NO	NO	NO	NO
34	A45		USA FAM MBR DECEASED AD	NO	YES	NO	YES	NO	NO
35	A47		USA FAM MBR DECEASED RETIRED	NO	YES	NO	YES	NO	NO
36	A48		USA UNREMARRIED FRM SPOUSE	YES	NO	NO	NO	NO	NO
37	A49		USA FAM MBR UNREMAR FRM SPOUSE	YES	NO	NO	NO	NO	NO
38	B00		NOAA DECEASED SPONSOR	YES	NO	NO	YES	NO	NO
39	B11		NOAA ACTIVE DUTY	YES	NO	NO	NO	NO	NO
40	B26		NOAA APPLICANT/REGISTRANT	YES	NO	NO	NO	NO	YES
41	B29	A	NOAA NEWBORN OF SPONSOR'S DAUGHTER	NO	YES	NO	NO	NO	YES

What's In the PATCAT Table – Part 5?



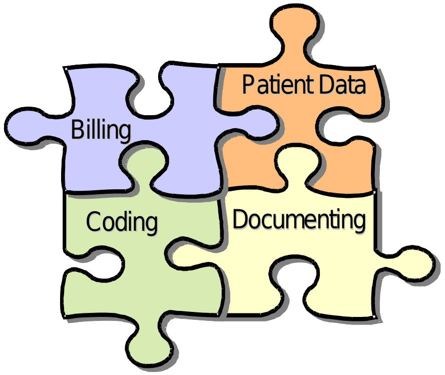
These are the permissible values for a change of Patient Category Code during an inpatient stay.



	A	B	C	U
1	**Code**	**Sub Cat**	**Name**	**To valid Patient Categories**
21	A25		USA FAM MBR FAD-TRANS ASSIST ACT	
22	A26		USA APPLICANT/REGISTRANT	
23	A27		USA FRM MEMBER-MATERNITY CARE	
24	A28		USA NEWBORN OF FRM SERVICE MBR	
25	A29	A	USA NEWBORN OF SPONSOR'S DAUGHTER	A25 ~A41 ~A43 ~A45 ~A47
26	A31	1	USA RET LOS OFFICER	
27	A31	2	USA RET LOS ENLISTED	
28	A32	1	USA RET PDRL OFFICER	
29	A32	2	USA RET PDRL ENLISTED	
30	A33	1	USA RET TDRL OFFICER	A11 1~A12 1~A12 B~A15 1~A15 B~A22 1~A22 B~A23 1~A23 B~A32 1
31	A33	2	USA RET TDRL ENLISTED	A11 2~A12 2~A12 B~A15 2~A15 B~A22 2~A22 B~A23 2~A23 B~A32 2
32	A41		USA FAM MBR AD	A25 ~K82 1~K82 2~K82 3~K82 4~K82 5~K82 6~K82 7~K82 8~K82 9~K91 1
33	A43		USA FAM MBR RET	K82 1~K82 2~K82 3~K82 4~K82 5~K82 6~K82 7~K82 8~K82 9~K91 1
34	A45		USA FAM MBR DECEASED AD	K82 1~K82 2~K82 3~K82 4~K82 5~K82 6~K82 7~K82 8~K82 9~K91 1
35	A47		USA FAM MBR DECEASED RETIRED	K82 1~K82 2~K82 3~K82 4~K82 5~K82 6~K82 7~K82 8~K82 9~K91 1
36	A48		USA UNREMARRIED FRM SPOUSE	K82 1~K82 2~K82 3~K82 4~K82 5~K82 6~K82 7~K82 8~K82 9~K91 1
37	A49		USA FAM MBR UNREMAR FRM SPOUSE	K82 1~K82 2~K82 3~K82 4~K82 5~K82 6~K82 7~K82 8~K82 9~K91 1
38	B00		NOAA DECEASED SPONSOR	
39	B11		NOAA ACTIVE DUTY	B31 ~B32 ~B33 ~K61 1~K61 2
40	B26		NOAA APPLICANT/REGISTRANT	
41	B29	A	NOAA NEWBORN OF SPONSOR'S DAUGHTER	B41 ~B43 ~B45 ~B47

CORE COMPETENCIES

Dissecting PATCAT Codes


Patient Data
Billing
Coding
Documenting

- Basic code covers a 'Category' of interest

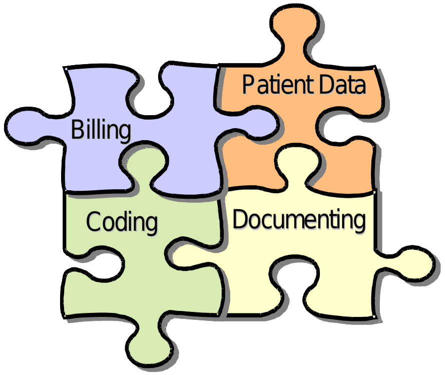
A11 = USA ACTIVE DUTY
K53 = OTHER FED AGENCY/DEPT EMPLOYEE

- Sub-categories segment the group

A11 A = USA ACTIVE DUTY OFFICER
A11 B = USA ACTIVE DUTY ENLISTED
K53 A = TREASURY DEPARTMENT
K53 B = HEALTH AND HUMAN SERVICES

CORE COMPETENCIES

Dissecting PATCAT Codes – First Position


Patient Data
Billing
Coding
Documenting

A = Army

B = National Oceanic and Atmospheric Administration

C = Coast Guard

F = Air Force

K = “Katch-all” (many “Other” and “Special” categories)

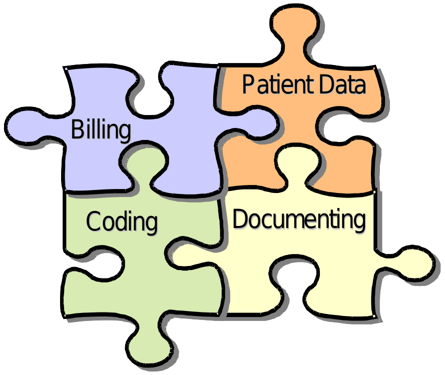
M = Marines

N = Navy

P = Public Health Service

R = Reciprocal Agreements (US with other nations)

Dissecting PATCAT Codes – Positions 2 - 3


Billing
Patient Data
Coding
Documenting

1x = Extended Active Duty Sponsors

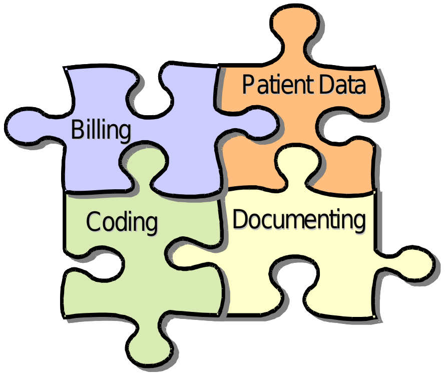
2x = ROTC; Inactive Duty Guard/Reserves, TAMP/TRS, Former Members, Applicants

3x = Retirees

4x = Family Members, Former Spouses and Family Members

5x – 9x = Used to segment “K” Codes

Common PATCAT Codes


Patient Data
Billing
Coding
Documenting

*11 = Active Duty

*31 = Retiree (Length of Service)

*41 = Family Member of AD

*43 = Family Member of Retiree

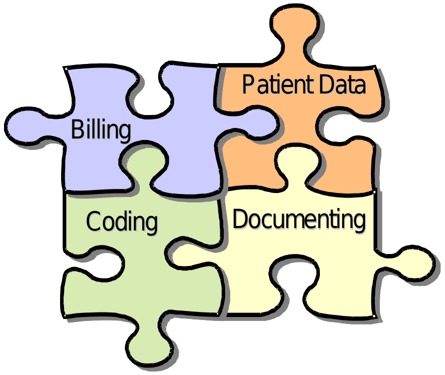
*29 A = Newborn of Sponsor’s Daughter

NOTE: The “*” above is for Sponsor Service (A,B,C,F,M,N,P)

K92 A = Civilian Emergency

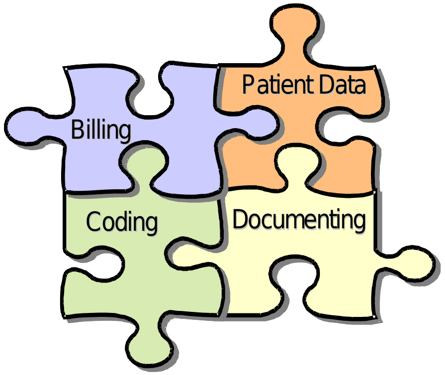
K99 = Patient Not Elsewhere Classified

Some PATCATs Are Strange! – Part 1



- Who are Supernumeraries (53 U)?
- They are SECDEF Designees…and they include:
  - President and Vice President of the US
  - Members of the Cabinet
  - Article III Federal Judges
  - US Court of Military Appeals Judges
  - Secretary, Deputy Secretary, Assistant, and Undersecretaries of Defense
  - DoD General Counsel
  - Director of Operational Test & Evaluation for OSD
  - Secretaries, Undersecretaries, Assistant Secretaries, and General Counsels of the Military Departments

Some PATCATs Are Strange! – Part 2



- Who are Supernumeraries (53 U)?
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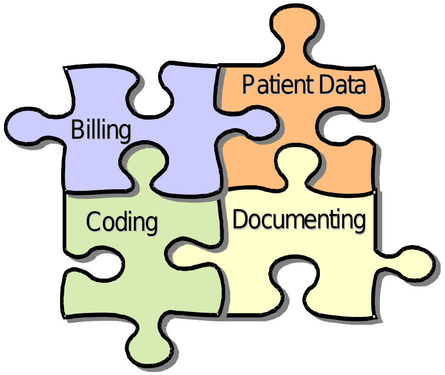
  - Article III Federal Judges
  - US Court of Military Appeals Judges
  - Secretary, Deputy Secretary, Assistant, and Undersecretaries of Defense
  - DoD General Counsel
  - Director of Operational Test & Evaluation for OSD
  - Secretaries, Undersecretaries, Assistant Secretaries, and General Counsels of the Military Departments

CORE COMPETENCIES

Some PATCATs Are Strange – Part 3

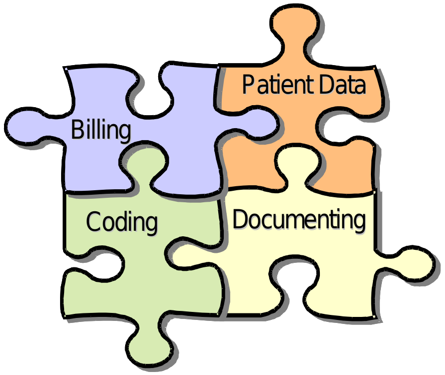


When Can We Charge Members of Congress and the Other Supernumeraries?

- Outpatient Care provided in National Capital Area (NCA) MTFs
  - Charges waived
- Outpatient care provided in MTFs outside the NCA
  - Members of Congress = Full Reimbursement Rate (FRR)
  - All Others = Interagency Rate
- Inpatient Care in MTFs anywhere
  - Members of Congress = Full Reimbursement Rate (FRR)
  - All Other Supernumeraries = Interagency Rate

CORE COMPETENCIES

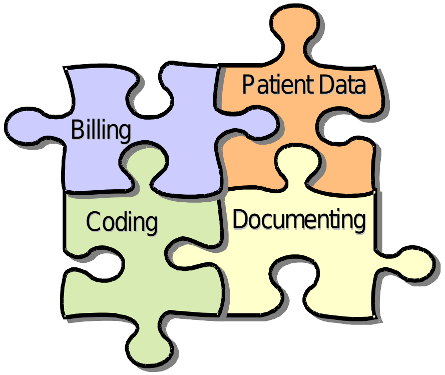
Some Rate Are Strange, Too!



- Flexible Rates are MTF-specific rate calculations used for specialized PATCATs
- Example: K76 C – GTMO
  - Care for local national civilians at the NH Guantanamo Bay requested by Navy/SG in Letter of 14 Jan 02
    - Inpatient Day Charge = $15.00
    - Outpatient Visit Charge = $45.00

CORE COMPETENCIES

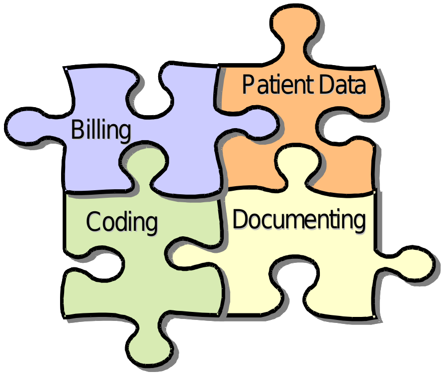
DEERS and CHCS May Be Out of Synch With Your Operational Reality!



- High OPS Tempo and creation of new benefits lead to lags in updating DEERS and CHCS
  - Activation/Deactivation of Reserve/Guard personnel
  - Entry into Transition Assistance Management Program (TAMP)
  - Entry into TRICARE Reserve Select
  - Moves from Active Duty to Retiree status

C O R E C O M P E T E N C I E S

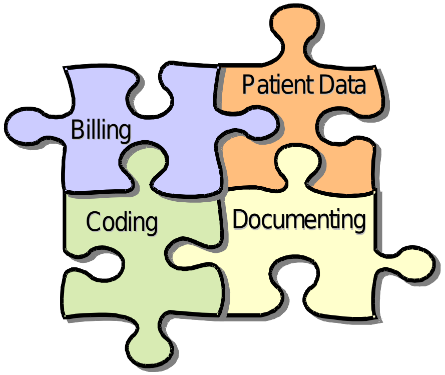
Some Patients Are Not What They Seem!


Billing
Patient Data
Coding
Documenting

- MHS Beneficiaries (Retirees, Family Members of AD or Retirees) who are also
  - Civil Service Employees
  - Contractors
  - DOD Dependent School System Employees
- Generally use the PATCAT based on the MHS Beneficiary

CORE COMPETENCIES

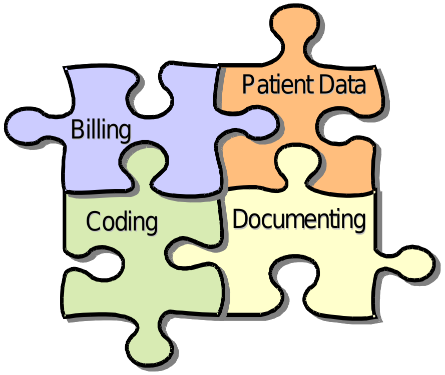
You Need the “Right” PATCAT For the Dates When Care Was Provided



- You may need to double-check the PATCAT data in CHCS against other data you have gathered
- Be sure to use a DEERS eligibility inquiry that covers the Dates of Service…DEERS may have been updated
- Be mindful that Reserve Component personnel can go from Inactive to Active to TAMP…and now to TRS all in the space of a few months

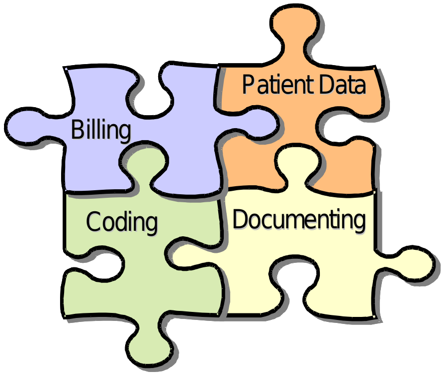
CORE COMPETENCIES

Recent Changes in PATCAT Codes


Patient Data
Billing
Coding
Documenting

- Removal of Subsistence Rate billing for officer and some enlisted personnel
- Use of “*24” and “*25” PATCAT Codes as interim solution for TRICARE Reserve Select
  - Program began 26 April 2005

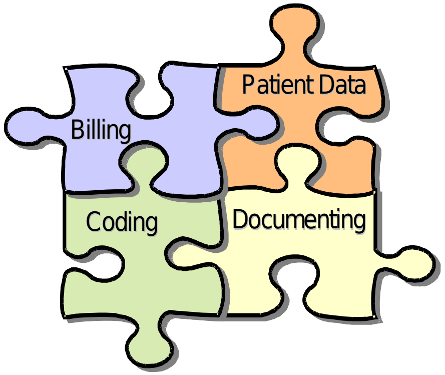
TRICARE Reserve Select

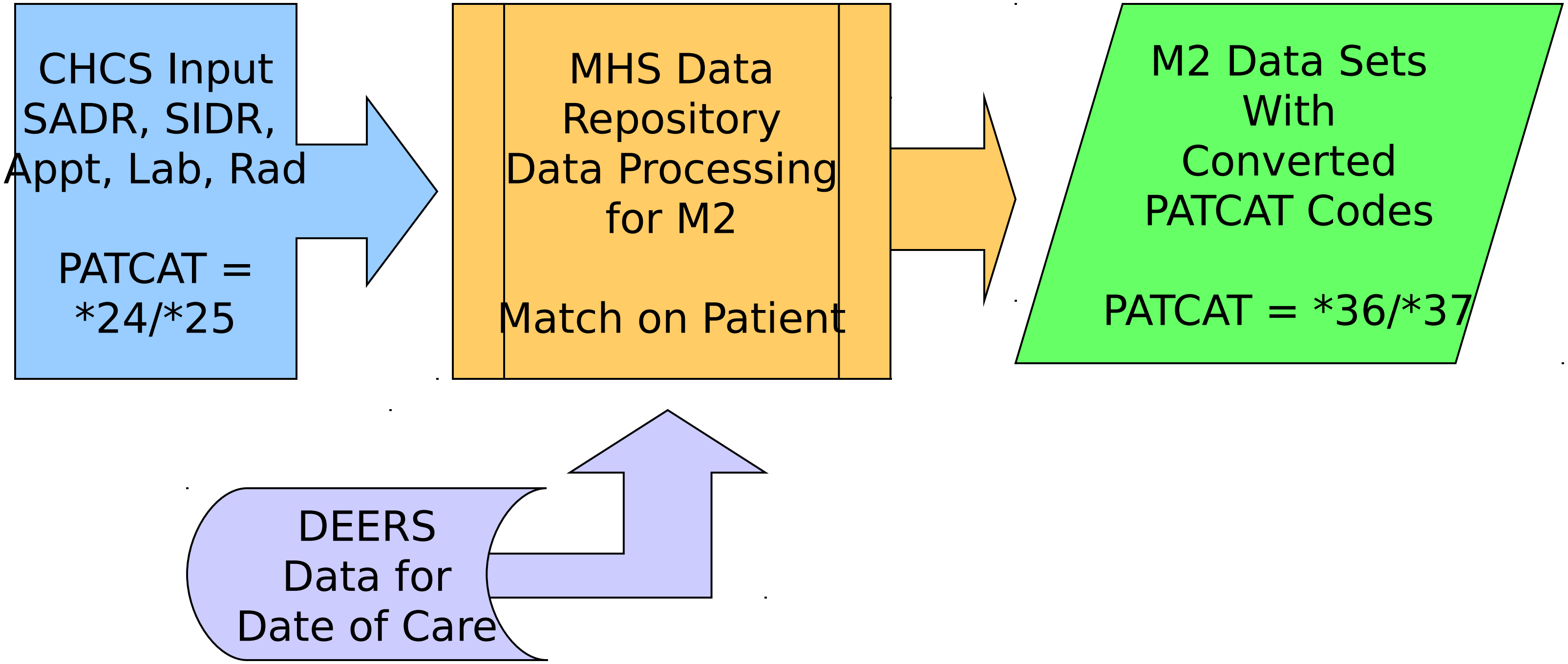


- New program under which a Member can ‘buy’ TRICARE for self only or self and family
  - Must have served on Active Duty more than 90 days
  - Must join Selected Reserve for one year or more
  - Must pay monthly premiums
- Interim PATCAT Codes in CHCS and other operational systems
  - *24 = Member participant in TRS
  - *25 = Family member participant in TRS
- Interim PATCAT Codes in M2 Tool
  - *36 = Member participant in TRS
  - *37 = Family member participant in TRS

CORE COMPETENCIES

TRICARE Reserve Select – Conversion of PATCAT Codes for M2 Use


Patient Data
Billing
Coding
Documenting



CHCS Input
SADR, SIDR,
Appt, Lab, Rad

PATCAT =
*24/*25

MHS Data
Repository
Data Processing
for M2

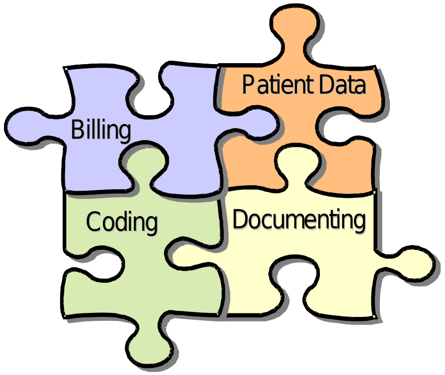
Match on Patient

M2 Data Sets
With
Converted
PATCAT Codes

PATCAT = *36/*37

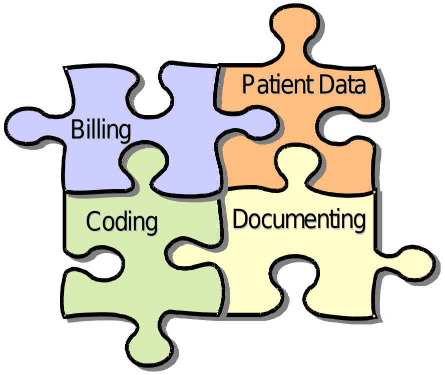
DEERS
Data for
Date of Care

Proposed Changes for PATCATs



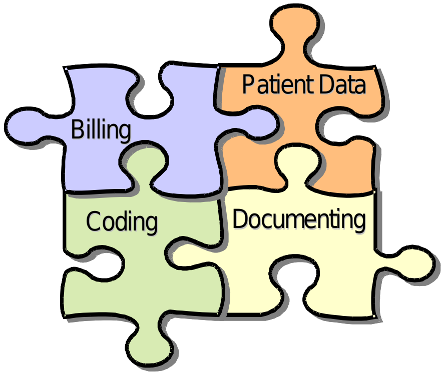
- Create new PATCAT Codes for TRICARE Reserve Select
  - *36 and "*37" recommended
- Add K53 Z for Non-Appropriated Fund Employee – CONUS
- Add new PATCAT Codes for Coalition Forces – OCONUS
  - K80 and K81 recommended
- Split K92 C – SOC SEC BENE/MCARE/MCAID/SCHIP into several separate PATCATs
  - Social Security – Medicare
  - State – Medicaid
  - State – Children's Health Insurance Program
- Expect implementation of changes to take several months
  - Watch UBO site and CHCS change packages for announcements

Where to Get Help With PATCATs



- MTF Colleagues - PAD staff are your friends
  - Understanding who has what entitlement
  - Investigating and resolving possible PATCAT errors
- Service UBO Points of Contact
- UBO Web Site: http://tricare.osd.mil/rm/ubo_home.cfm
- UBU Web Site: http://www.tricare.osd.mil/org/pae/ubu/default.htm

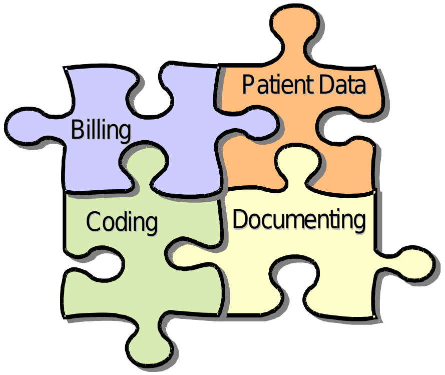
Summary


Patient Data
Billing
Coding
Documenting

- Purpose: PATCATs group patients to support tracking, reporting, billing
- Importance: Used by many functions and systems; linked to billing for services
- Structure: Service/Civilian; Category; Sub-Category
- Help: Colleagues in PAD; Service POCs; UBO Web site; UBU Web site

CORE COMPETENCIES

Patient Category Codes (PATCATs)


Patient Data
Billing
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Documenting

- Questions?